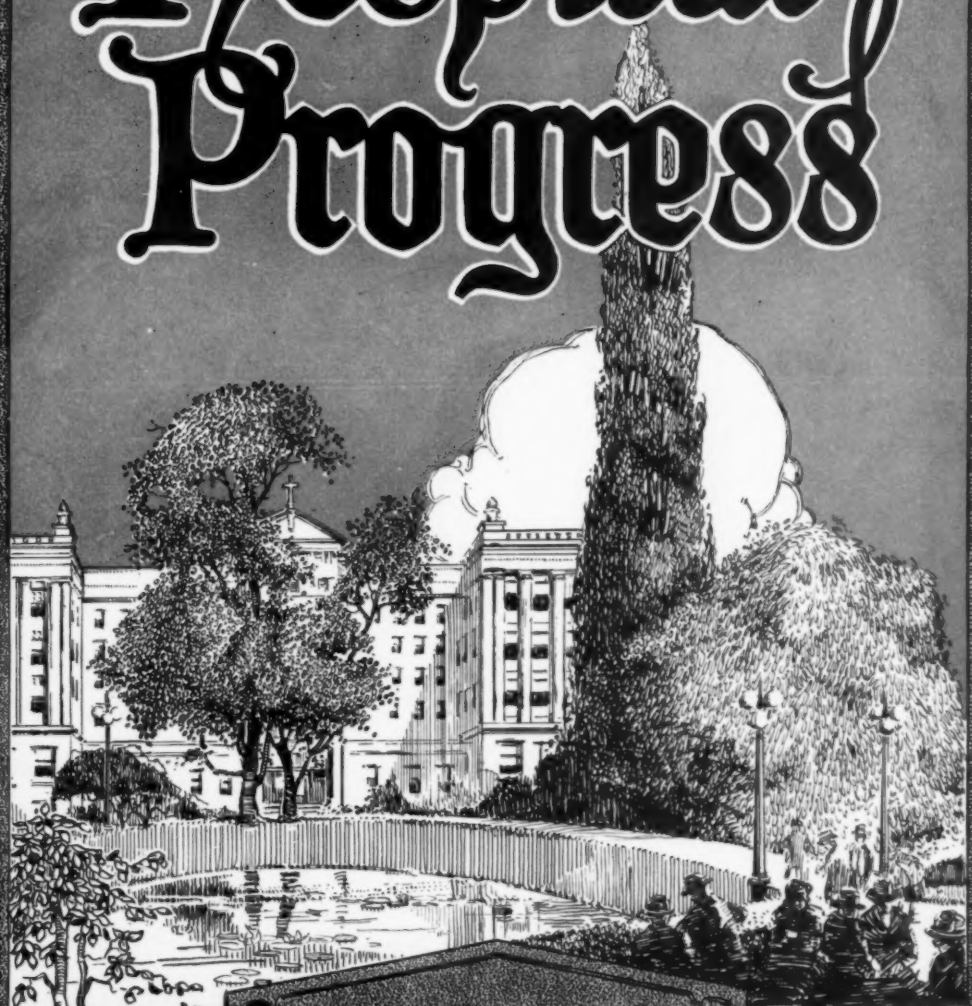
Hospital Progress



Official Magazine of the Catholic Hospital Association

JULY, 1922

St. Mary's Hospital

Sisters of St. Francis

Rochester, Minn., July 7, 1914

Scanlan-Morris Company,
Madison, Wisconsin.

Dear Sirs: Your "White Line" sterilizers have been in use in St. Mary's Hospital for the past ten years, giving us efficient, durable service. We have, in all of our new surgeries recently equipped, installed "White Line" Sterilizers and Furniture throughout.

Sincerely yours,

(Sister M. Joseph.)

May 12, 1922

The new three-hundred room surgical pavilion, St. Mary's Hospital, Rochester, Minnesota, formally opened today, with its modern ampitheater, eleven operating rooms, eight sterilizing rooms, and numerous dressing rooms, is equipped with "White Line" sterilizers, operating tables, and apparatus.

To hospitals seeking equipment of proven efficiency,—equipment of the highest merit, we offer our experience and service. "White Line" catalog sent on request.

Scanlan-Morris Company

"The White Line"

Madison, Wisconsin.

Chicago Display Room: 411 Garland Building

HOSPITAL PROGRESS

Official Magazine of the

CATHOLIC HOSPITAL ASSOCIATION
OF THE UNITED STATES AND CANADA

BOARD OF EDITORS

Executive Committee

REV. C. B. MOULINIER, Milwaukee, Wis., Chairman.
B. F. McGRATH, Milwaukee, Wis., Secretary
EDWARD EVANS, M.D., La Crosse, Wis.
FREDERICK A. STRATTON, M.D., Milwaukee, Wis.
EDWARD L. TUOHY, M.D., Duluth, Minnesota
WILLIAM C. BRUCE, Milwaukee, Wis.

Contributing Editors of the United States and Canada

JOHN T. BOTTOMLEY, M.D., Boston, Mass.
HUGH McKENNA, M.D., Chicago, Ill.
FRANK S. MILEY, M.D., Fond du Lac, Wis.
REV. MICHAEL P. BOURKE, Ann Arbor, Mich.
REV. MAURICE F. GRIFFIN, Youngstown, Ohio.
HORATIO B. SWEETSER, M.D., Minneapolis, Minn.
AUSTIN O'MALLEY, M.D., Philadelphia, Pa.
EDWARD T. DILLON, M.D., Los Angeles, Calif.
MICHAEL F. FALLON, M.D., Worcester, Mass.
WILLIAM C. MAC CARTY, M.D., Rochester, Minn.
JAMES J. WALSH, M.D., New York, N. Y.
VERY REV. JOSEPH SCHREMBS, Cleveland, Ohio.
EUGENE SAINT-JACQUES, M.D., Montreal, P. Q., Canada
J. ALEXANDER SAINT-PIERRE, M.D., Montreal, P. Q., Canada.
JOSEPH BYRNE, M.D., New York, N. Y.
IRVIN ABELL, M.D., Louisville, Ky.
REV. PETER P. FINNEY, C.M., Dallas, Tex.
REV. P. J. MAHAN, Chicago, Ill.
CHARLES LOUIS MIX, M.D., Chicago, Ill.
EDWARD L. MOOREHEAD, M.D., Chicago, Ill.
REV. EDWARD F. GARESCHE, St. Louis, Mo.

Editorial Office: The Catholic Hospital Association, 221 Grand Ave., Milwaukee, Wis.

Volume III | JULY, 1922 | No. 7

TABLE OF CONTENTS

The Training of the Intern and Its Influence on the Future of Medicine..Edward F. Ziegelman, M.D...255
The Minimum Standard.....J. L. Pritchard, M.D.....258
Conservation of Health in Religious Communities.....By a Hospital Sister.....261
The Patient's Viewpoint—Conclusion.....Paluel J. Flagg, M.D.....264
SECTIONAL CONFERENCES:
Southern States Conference.....268
The Work of an Up-to-Date Hospital Laboratory.....F. G. Ellis, M.D.....270
The Hospital Laboratory.....Geo. Walter, M.D.....271
Post-Operative Pneumonia—Its Treatment in the Congestive Stage.....S. W. Boyce, M.D.....273
The Dietitian and the Hospital.....F. H. Walke, M.D.....274
The Necessity of a Dietitian.....Sister Mary Victory.....275
Editorial.....278
Program Announcement.....281
STAFF DOCTORS' SECTION:
Surgical Technique Employed at U. S. Public Health Service Hospital No. 35.....284
NURSES' TRAINING SCHOOL SECTION:
The Value of "Visualizing" Established Scientific Data or the Importance of "Little Things".....Georgine Luden, M.D.....287
Commencement Exercises at Mercy Hospital Training School, Baltimore, Md.....290
Nurses' Graduation, All Souls' Hospital, Morristown, N. J.....291
Graduation Day at St. Joachim's Hospital.....291
Commencement at Mercy Hospital, Hamilton, O.....291
Commencement Exercises at Mercy Hospital, Pittsburgh, Pa.....292
How Hospital Day Was Observed in Catholic Hospitals.....293
The Question Box.....296
Flashes of Fun.....296
Hospital News.....XX
Nurses' Training School Notes.....XXVII
New Trade Products.....XXXII

Published Monthly for the Association by
THE BRUCE PUBLISHING COMPANY, Milwaukee, Wis.

PUBLICATION OFFICE: 129 Michigan Street
EASTERN OFFICE: New York: 1 Madison Ave

Entered April 23, 1920, as Second Class mail matter in the Post Office at Milwaukee, Wis., under the Act of March 3, 1879. Copyright, 1922, by the Catholic Hospital Association.

SUBSCRIPTION INFORMATION

The subscription price of the Magazine is $3.00 per year, payable in advance. Postage for foreign subscriptions, 50 cents; for Canadian and Mexican subscriptions, 35 cents. Single copies, 40 cents; more than six months old, 50 cents.

Notice of change of address should invariably include the complete old and new forms of address. Complaints concerning the non-receipt of subscribers' copies cannot be honored unless made within fifteen days after date of issue.

CONTRIBUTIONS

The Executive Committee of Editors invites contributions of all kinds bearing on Hospital Problems. Unless otherwise arranged for, manuscripts, drawings, photographs, news items, etc., should be addressed to the Editorial Office, 1212 Majestic Building, Milwaukee.

Two Important FEATURES—

Unlosable Washer
(Cannot Drop Off)

Pleat All Around
(Gives Large Capacity)

ALL "Meinecke" Ice Bags are fitted with our patented Unlosable Washer and have a pleat all the way round to give extra capacity. These Ice Bags are made of our well known Maroon Rubber which will not get hard, soft, crack or peel off, and they can be depended upon to give the maximum Ice Bag service, either from the viewpoint of durability or utility.

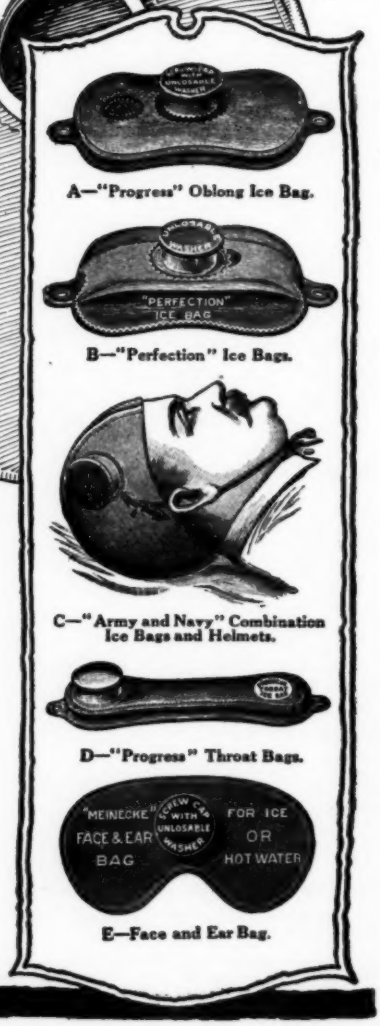
A—Progress Oblong Ice Bag. Size 7x11. Made of Cloth-Inserted Maroon Rubber. The best all-around Ice Cap made.

B—Perfection Ice Bags. Made in three sizes, namely, small, 5x9, medium, 6x11, large, 7x13 inches. The upper part is made of Cloth-Inserted Maroon Rubber, and the lower part of all Rubber Stock. The box-like pleats permit this Bag to assume a square shape when filled.

C—Army and Navy Combination Ice Bags and Helmets. Made in two sizes, namely, large size, (for adults) 12½ inches in diameter, small size, 10 inches in diameter. Made of Cloth-Inserted Maroon Rubber. This is an unusually good Ice Bag for use in fever cases, as the ice can be centered over the base of the brain. Loops are provided for tying on, in case the patient is delirious. This Ice Cap can be flattened out to form a large round Ice Bag, for use when a large area is desired to be covered, especially over the chest or abdomen.

D—Progress Throat Ice Bag. Made of Cloth-Inserted Maroon Rubber in two sizes, namely, small size, 10 inches, large size, 12 inches. For application to the Throat or head.

E—Face and Ear Bags. Made in one size only, of all Rubber Stock, for use on the forehead, back of the ear or back of neck and over the head. This Bag can be used for either Ice or Hot Water. For tying on purposes this Bag is provided with a linen bandage which fits over the Cap.



A—"Progress" Oblong Ice Bag.

B—"Perfection" Ice Bags.

C—"Army and Navy" Combination Ice Bags and Helmets.

D—"Progress" Throat Bags.

E—Face and Ear Bag.

MEINECKE & CO., *New York.*

Hospital Progress

Volume III JULY, 1922 No. 7

The Training of the Intern and Its Influence on the Future of Medicine

Edward F. Ziegelman, M. D., Portland, Ore.

TWENTY years ago the most progressive medical schools in the country requested that their graduates endeavor to obtain a hospital internship. Fortunately the past decade has seen a great impetus to this movement, so much so that practically all institutions of medical education at the present time are insisting that their graduates complete a well-regulated hospital service. To stimulate this intern service their catalogs contain paragraphs on the importance of such work, and point with pride to the fact that such-and-such a percentage of their students has succeeded in obtaining such-and-such choice appointments. Certain states wisely, through legislation, compel all applicants seeking state licenses to show evidence that they have completed a satisfactory period of training in some hospital before they are granted the privilege to practice in that particular state.

What has brought about this gradual progressive change? Certainly not the ambition and enthusiasm on the part of the neophyte doctor. Human nature is no different today than it was twenty years ago. Possibly a greater percentage of present day graduates are of a higher degree of mental efficiency, not because of greater mental potentiality but due to higher educational requirements demanded of the present day matriculant. The request, and in many cases the insistence, that a graduate obtain a satisfactory hospital service was brought about by the wisdom and farsightedness of the thinking men in medicine, who realized that unless a man had completed some such satisfactory training he was wholly unqualified to practice his profession so far as service delivered to the American people was concerned. It is not my purpose to discredit the older practitioners of the present day who have been less fortunate than many of the younger members of the profession. It is greatly to the credit of our pioneer medical men, who so wisely foresaw the importance of such a training and the disadvantages to both the public and physician in case such a training was not made possible.

A prominent surgeon once said that our present-day graduate is only twenty per cent efficient as to qualification to practice on the public in comparison with one who has served a satisfactory hospital service. If a young man does not obtain this training in a hospital qualified to train him properly, he must obtain that experience at the expense of the general public, usually without the wisdom and guiding influence of older men. It can readily be seen that such a state of affairs is very poor economics for a community. Such being the case it is quite evident that we as doctors, and hospitals as institutions, are deeply interested in this problem not only as professional people but as citizens.

The hospital standardization program has for its ultimate purpose improved medical service to the American public. It recognizes that the individual possesses a physical, mental, spiritual and social status. In the ultimate analysis it is endeavoring to develop a higher degree of medical efficiency. It does not desire to develop theorists or pseudo scientists but practical doctors who are qualified in diagnosis, possessing an ethical conscience and an understanding of the rational of modern therapeutics, whatever form of therapy best suited to the condition to be treated.

An internship implies certain obligations on the part of the young man having this privilege, as well as on the part of the institution granting it. Unless these obligations are realized and understood by both parties a great portion of the benefits to be derived are lost. Unfortunately there are some hospitals today that do not realize this. Regardless of the great progress made in better hospital service some institutions are still so organized that when a young man presents himself for service he receives a white suit of ducks, is called doctor and in many cases is allowed to shift for himself without any supervision over his activities on the part of the staff or hospital management. He spends a great portion of his time in the operating room, does an occasional dressing without instruction,

549664

is jollied from day to day, caters to and idolizes the man with the greatest number of cases who at times is the poorest type of individual to train him. His ideals and discipline diminish in direct proportion to the length of his service. The incentive or stimulus to scientific thought and perusal of medical literature, let alone the development of cultural characteristics is not made possible. Of course the element of the personal equation is very important and we all know there are some individuals so constructed who do very well under such a regime, though the balance of equation is that such a condition is not to the best interest and training of the young man.

Until the profession of medicine and its workshop, the hospital, realize the importance a satisfactory training means to the future of medicine, and until they insist upon certain basic principles in regard to the professional and executive aspect, I fear that our program of standardization will be rather slow. Unless some such principles are insisted upon we may expect to see the various isms, pathies, sects and cults developing rapidly and usurping the public confidence.

No institution should profess to give a high degree of training to a young medical man unless it

(1) Endeavors to obtain the best graduate material possible for its service.

(2) Organization of departments

(3) Organization of Staff

(4) Proper quarters, living and library facilities.

(5) Insistence on hospital discipline and deportment.

I fear that at times the value of the best material in the development of an intern is neglected. No corporation or business house would tolerate anything but the highest type of men in these important positions. It is a very difficult problem for a hospital to say that this or that man will prove to be satisfactory during his period of residency, so many factors must be considered, such as the physical, spiritual, mental and social makeup of the applicant. We all know that competition is very keen among recent graduates in their endeavor to gain the choicest appointments. Why should not the same apply to the hospitals. Scholarship is rather difficult and at times an unjust method of selection, though I still contend that competitive examination will result in obtaining the greatest number of qualified all-around men as interns. Institutions that are so situated are missing a golden opportunity in not permitting undergraduates to do extern work during their last summer vacation. Where this is permitted the psychological attitude of the prospective candidate is observed, a mighty important requisite especially from the hospital viewpoint.

Departmental organization covers such a wide field and in reality is the bulwark of the intern's training that too much time and care cannot be given it. The size of the hospital is of very little importance. Any institution that professes to be a hospital can have a well organized and functioning department of clinical medicine with all that this implies, such as X-ray facilities, clinical laboratories where all modern laboratory tests of tried value are performed, a department of surgery, surgical pathology and a department of specialties. The size of the hospital and the community in a measure will regulate the breadth and scope of these departments and whether they should be further subdivided into the more restricted specialities. It seems needless to mention the value that should be placed on the taking of satisfactory histories and the importance of recording accurately all data of the work performed in the various departments. This work is essentially that of the intern and should be carefully supervised and analyzed by the respective attending men. Unless this is carefully regulated a great deal of the benefit due the intern will be lost.

Proper staff organization is closely allied to departmental organization. If the staff is unqualified as to leadership in their respective fields how can a department expect to function properly? It is not the question of open or closed hospitals, but whether your staff men are qualified and is the personnel of the courtesy staff such that they will be able to carry the responsibilities of staff men when called upon to do so. Unfortunately here again comes the element of the personal equation. Naturally men who bring the greatest amount of work to an institution will have the greatest amount of material for clinical purposes. I venture to say that many men who never attain anything more than very mediocre positions because of lack of professional work would make very excellent staff leaders. No hospital department should be supervised by any doctor who has not a broad working knowledge of general medicine, as well as the speciality that he may be interested in. He must be able to instill enthusiasm and ideals into the minds of the young men and be more or less free from fads. A little less material with more enthusiasm, ideals and diagnostic efficiency might attain the best results in regard to all concerned. Staff meetings where histories are analyzed, autoposies are reported and follow up records are discussed are of such importance to the hospital, interns and staff members that attendance at such meetings should be made compulsory.

One of the objects of an internship is educational in the various branches of medicine. It is self evident that the presence of a library is very important. One large room in an institution utilized for this purpose is of inestimable value. It naturally becomes the rendevous of the staff men and it is the place where many of the ideals are inculcated into the younger minds. It is the place for friendly discussions, an exchange of views and opinions and many a practitioner today looks back to his hospital training and recalls the happy moments spent in the library and the valuable advice

and counsel that he received there. It is not necessary to have innumerable volumes upon the shelves. A few standard reference books, with a good supply of modern up to date medical journals is sufficient. It instills, or at least keeps alive, studious habits in the intern, and is of great value to the visiting men as well.

It is a peculiar fact that most young men when seeking an unfamiliar hospital appointment first inquire of some friend who may be serving such an internship, or from one who has completed such a service the professional value of the appointment. Invariably the second question asked is; how are the boarding and living conditions? It is unfortunate that this inquiry is so common. The reason is possibly in a measure, due to leaving a condition in college life where living and dietary conditions have not been the best because of financial embarrassment on the part of many medical students. It is true that men can do better work when properly housed and fed. It is conducive to happiness and contentment, a factor of no small importance in the organization and efficiency of a hospital. The question of salary is debatable. Some men are so ambitious, enthusiastic and desirous of obtaining a good service that salary is no incentive. I feel that the time is very near when most hospitals will have to pay a small stipend, unless they have such a reputation that the value of the service they give places them in the preferred class. Most young men graduating in medicine are without finances. It does not seem altogether fair to cast them out into the world after serving an internship in the same condition. Some of my professional brethren will disagree with me on the salary question. There are arguments for and against. It depends a great deal upon the financial status of the applicant just as his length of service and location of practice does.

Insistence on hospital deportment and discipline seems rather unnecessary to mention, still it plays a very important role in the systematic work and ultimate training of the young graduate. Insisting upon gentlemanly conduct toward the visiting staff, nurses and hospital management goes without saying. Insisting upon routine hours of work and the completion of the work in a satisfactory manner is appreciated by all. I fear that at times we doctors are not sufficiently stern with the younger men, though I assure you that the hospital requiring a fair degree of discipline and the visiting men who demand it will be the most appreciated in time.

I have attempted to touch only a very few of the salient features of a satisfactory internship. There are so many more that an article of this kind cannot hope to cover the subject in its entirety. It has been my purpose to impress upon the reader the importance that the intern of the present bears to the future of medicine, and the responsibility that the hospital through its management, staff and organization has in the development of the future men and women of our profession. They may be considered to be the babes of the profession, and just as the twig is bent so shall the tree develop. Let us not forget this great duty to the intern and let us try to exert our best energies to the development of his professional activities, in the ethics based upon a conscience and try to instill into him ideals and enthusiasm of better medicine. If we succeed in so doing we will have accomplished a great deal toward the progress of higher standards.

GRADUATING CLASS OF 1922. PROVIDENCE HOSPITAL, EVERETT, WASH.

The Minimum Standard[1]

J. L. Pritchard, M. D., San Jose, Calif.

GRADUALLY during the past few years there has been taking form in the minds of the leaders in the medical profession an ideal, which today is fast becoming a reality. Call it what you will: in plain words it means a square deal for the patient, for the hospital, and last but not least, for the Doctor. Consider for a moment the standing of the medical profession in the public mind of today. Is it an enviable one? We need not go beyond the confines of our own state to perceive conditions of ominous portent. Let us pause for a moment to contemplate the factors which are responsible.

Of the many, let us first reflect on the beam in our own eye. Have we individually, or collectively, done our part toward putting a great profession on a firm foundation, or have we both by sins of omission and commission, so undermined our structure that we are falling into pits of our own digging. Just as a chain is no stronger than its weakest link, so is the medical profession influenced in the minds of the public by the deeds of our weakest as well as our strongest brothers. I shall leave to your imaginations the opportunity to pursue this intimation further.

Among all the professions of any scientific attainment, the medical profession is at once the most ultra scientific, and the most unscientific. If some ignorant, selfish, doctor wishes to pursue his calling in the most unethical, immoral, unscientific manner, who is to say him nay. Indeed, there are safeguards for both the medical profession and the patient, *when they function:* for the profession, the county medical society; and for the patient, the hospital. But too often both are scandalized.

This brings us again to the ideal which was referred to in the opening paragraph, the so called standardization of hospitals. In 1913 the American College of Surgeons was formed, ostensibly for the purpose of raising the standard of surgeons. This was to be attained by admitting to membership only those who were known to be qualified to do surgery. That done, very logically came the desire to improve the conditions under which surgery was performed, and so the idea of the "minimum standard for hospitals" was conceived.

During the past four years representatives of the American College of Surgeons have been visiting hospitals throughout the United States and Canada, endeavoring to help the hospitals to become better, with a result that 550 of the 697 hundred-bed hospitals have accepted the minimum standard. In this movement the hospitals have taken the lead. They have been anxious to have a survey by a representative of the College because, as Dr. Franklin H. Martin remarks, "They were getting tired of running boarding houses in which all kinds of patients were dumped by all kinds of doctors."

Function of the Hospital.

Most of us use hospitals for our patients from time to time, but some of us may not have really appreciated what a hospital means to a community. Let us take the charter of any hospital and read the words of the first paragraph. It will read to this effect: "A hospital is an institution that exists to give the best care to the sick and injured, and the responsibility for this care rests upon the Board of Trustees." Now, standardization means, as previously stated, "A square deal for the patient, the hospital and the doctor," and nothing more. For the practical application of this idea, three things are essential, namely, case records, adequate laboratory facilities, and staff organization.

"These three factors we must accept. We cannot do otherwise, because they are fundamentally correct," as Father Moulinier has so well said, show me the community or the hospital where any really constructive work in medicine has been accomplished, and there you will find organization, case records, and adequate laboratory facilities.

A Staff of five, ten or 20 members can be organized in any community, but it will never amount to anything unless there are active meetings, at least once a month, where case reports of patients for the month are discussed. Records may be kept but they will not amount to anything unless they are honestly, scientifically, and fully written, taking into consideration everything that has been done for the patient previous to operation or other treatment, what was done for the patient at the hospital, and the results as shown by follow-up records. Laboratories must be fully equipped, with a trained pathologist in charge; but, above all, there must be organization, team work, and an ethical spirit of cooperation.

It is said that the greatest obstacle in the way of developing this minimum standard has been a lack of the spirit of cooperation on the part of the medical profession. But the time has come when we must work together; especially is this imperative in a community like ours. We must develop our hospitals, our laboratories, our staff organization, and our case records until they are on a par with any that our competitor cities have to offer. If it is not sufficiently convincing to state that all this is due our patients, let me add that it is fast becoming a necessity for our own security.

Dr. Arthur D. Bevan in a recent address before the American Conference on Hospital Service stated, that in order to accomplish these tasks we require the active, enthusiastic support of the medical profession. He goes on to say that he does not believe that the medical profession has realized the importance of its work in each

[1]Read before the Santa Clara County Medical Society, Jan. 18, 1922.

of its county societies. If the medical profession in every county realized that its most important function was to see that the people in its own particular community secured proper medical care, and had proper hospitals to take care of its sick, a great deal would be accomplished.

Promoting Medical Betterment.

He does not think that the most important function of the county society is to read papers and meet occasionally, but rather to bring to the people the particular benefits of scientific medicine by promoting an intelligent plan for medical betterment.

In studying the different constitutions and by-laws recently adopted by many different hospitals in this Country and Canada one is struck by the uniformly progressive principles of all. Particularly, all include the three essentials of the minimum standard—records, laboratory facilities, and staff organization; and many stress such factors as securing autopsies whenever possible, holding daily clinics by the better prepared men for other doctors, stimulating research work, and urging regular yearly or bi-yearly post-graduate work for all staff members.

For over a year the O'Connor Sanitarium has been accredited by the American College of Surgeons as one of the hospitals accepting the minimum standard. Much has already been done toward meeting all the requirements, but so far we have only had the preliminaries. We are now ready for the principal part of the program. So far the hospital has done by far the greater part. The Sisters deserve great credit for the generous manner in which they have installed new apparatus for the laboratory, equipped a splendid record room, employed a highly trained business woman as historian, also secured the services of a full-time pathologist. Laboratory equipment recently purchased includes the necessary apparatus for blood chemistry, a Spencer combination freezing microtome, an extra microscope, a Dubosq colorimeter, and a Boothby-Saniford Gasometer, with the Haldane gas analysis apparatus for the determination of basal metabolism.

It now remains for the doctors to do their part toward medical progress by utilizing these splendid facilities placed at their disposal. The means for accomplishing this are already under way. The constitution and by-laws have been recently revised and will go into effect after the staff meeting in March. The rules and regulations adopted will govern the staff in strict conformity with the principles outlined in the minimum standard. Not only the members of the staff, but all the doctors who have the privilege of using the hospital, will be required to observe the rules and regulations of the Sanitarium. It is imperative that this be done because the Sisters and the hospital staff have given their word to the American College of Surgeons to carry out the principles of standardization; consequently, it must be done. There can be no turning back. Fortunately a sufficient number of doctors has already pledged themselves to this program to insure its success.

It may appear to those who are unacquainted with the requirements, that something radical is being inaugurated. Such is not the case, as a study of the constitution and by-laws, which follow, will show:

Constitution and By-Laws of the O'Connor Sanitarium Staff.

Sec. 1. **Name.** The name of this organization shall be "The O'Connor Sanitarium Staff."

Sec. 2. **Aims of the Organization.** The chief aims of this organization shall be to secure and maintain high standards of medical and surgical efficiency, and thus promote to the maximum the welfare of the patients and nurses coming under its influence, and to further the scientific advancement of its members.

These objectives are to be achieved by having a carefully chosen competent staff, well kept honest records, well equipped clinical laboratory, and regular meetings of the staff doctors to discuss the records, and to propose means for progress.

Sec. 3. **The Advisory Board.** There shall be an Advisory Board composed of the Sister Superior of the Sanitarium, and seven other members, five of whom shall be members of the staff.

Sec. 4. **Duties of the Advisory Board.**

(a) It shall be the duty of the advisory board to provide for the general organization and supervision of the activities of the staff, and to correlate its work with the administration of the Sanitarium.

(b) It shall receive applications for membership on the staff and after due examination of the applicant's qualifications shall make appropriate recommendations to the staff for action.

(c) It shall have the power to remove from the Staff, or from the list of physicians enjoying the privileges of the sanitarium any member who, after due procedure, is convicted of conduct unbecoming a gentleman, and a member of the profession.

Sec. 5 **The Staff.** The staff shall be composed of physicians who are members of the California State Medical Society, or its equivalent, and whose qualifications are approved by the advisory board.

Sec. 6. **Annual Meeting.** The annual meeting of the staff shall be held at the sanitarium on the second Tuesday of March at 8 o'clock P. M., at which time there should be elected, the following officers of the staff: A President, a First and Second Vice President, a Secretary-Treasurer, whose tenure of office shall be one year, or until their successors are elected.

Sec 7. **Monthly Meetings.** The staff shall hold a meeting on the second Tuesday of each month, for scientific discussion, the consideration of case records and other matters which shall be brought before it by the advisory board.

Sec. 8. **Unclassified List.** Physicians not members of the staff may be permitted to practice in the sanitarium, as heretofore. Their qualifications shall be the same as for members of the staff, and they shall be subjected to the same rules and regulations of the sanitarium.

Sec. 9. **Regulations.** All physicians having patients in the O'Connor Sanitarium will be bound by the regulations of the staff and of the institution.

Sec. 10. **Amendments.** Amendments to this constitution may be made as provided for in the By-Laws.

By-Laws.

1. Each physician and surgeon practicing in this hospital must write his prescriptions and directions for nurses and attach his signature. When oral and telephonic instruction are given, they must be written by the nurse by whom taken, and initialed by the physician on his first visit thereafter.

2. All material removed from the patient by operative procedure is the property of the hospital and must remain in the laboratory for a sufficient time to allow the pathologist to make a permanent record of the same.

3. All major surgical cases (except emergencies) must enter the hospital 24 hours before the time set for operation, in order that they may be properly prepared, have histories written, and the necessary tests made. Patients for tonsillectomy must be in the hospital at least two hours before operation.

4. No surgical operation shall be performed without the written consent of the patient or his legal representative.

5. The interns on duty and the members of the staff may be present at any and all operations.

6. Members of the family are excluded from the operating and obstetrical rooms, except in cases where their presence is required.

7. All members of the staff shall pledge themselves to the following principles: "I hereby agree that I shall not engage in the division of fees under any guise whatsoever. By this principle I understand that I am not to collect fees from others referring patients to me, nor knowingly to permit any agent or associate of mine to do so.

8. All members of the staff and all visiting physicians and surgeons will be required to have a permanent record on file when the patient leaves the hospital. This record is to include:

(a) Personal History—1. Present complaint, 2. Onset and course.

(b) Past History—1. Family History. 2. Habits Positive and Negative.

(c) Menstrual and obstetrical history in females.

(d) Physical Examination: This should be complete and include the nervous and lympathatic system. The attending physician is held responsible for all examinations, though they may be made by an assistant or an intern.

(e) Working diagnosis and final diagnosis when the case is completed.

(f) Laboratory, X-Ray and pathologist's report.

(g) Progress notes at least every 48 hours with signature of physician.

(h) Pre-operative diagnosis, description of operation and gross pathology written immediately after the operation and signed by the surgeon with post-operative diagnosis.

(i) In case of death, necropsy findings if necropsy is performed.

9. Surgeons must be in the Operating Room and prepared to begin operating at the hour scheduled. Operating room will not be held more than thirty minutes beyond scheduled hour.

10. Any member of the staff who shall be absent from two consecutive staff meetings in any one year without the consent of the advisory board shall automatically cease to be a member of the staff.

11. All attending physicians should become familiar with the routine of the hospital and carry it out as far as possible. Orders out of this routine should be written on the chart.

12. All surgical cases must have written pre-operative diagnosis before patient will be admitted to operating room, in addition to the complete history, except in cases of emergency.

13. The following surgical code—a copy of which is posted in the surgery is in effect in this Hospital: The following operations are unethical and may not, therefore, be performed.

1. Operations involving destruction of foetal life. Such are:

(a) Dilitation of the os-uteri during pregnancy and before the foetus is viable.

(b) Introduction of sounds, bougies, or any other substance within the os-uteri during pregnancy and before the foetus is viable.

(c) Induction of labor by any means whatsoever before the foetus is viable.

(d) Curettment of the uterus during pregnancy.

(e) Cranitomy of the living child.

(f) Operations directly attacking a living foetus in extra-uterine pregnancy, in the absence of maternal shock from hemorrhage and before foetus is viable.

Where operations for extra-uterine pregnancy in the Fallopian tube are performed the rent or rupture in the tube must be repaired whenever possible.

2. All operations involving the sterilization or mutilation of men or women, except where such follows as the indirect and undesired result of necessary interference for the removal of diseased structures.

Operations specifically forbidden are:

(a) Removal of an undiseased ovary. Whenever an operation for the removal of a diseased ovary is performed, enough of such organ must be left intact if possible, as will permit the same to function.

(b) Removal of a Fallopian tube which is not so diseased as to require removal.

(c) Section of an undiseased Fallopian tube.

(d) Operations which result in obstructing the lumen of an undiseased Fallopian tube.

(e) Hysterectomy where the uterus is not so badly diseased as to require an operation.

(f) Ventral suspensions and anterior fixations or Ventro-fixations so-called in women of child-bearing age in the absence of proof positive of their necessity.

(g) The sterilization and castration of male patients.

The foetus may be considered viable after six calendar months.

If the foetus is known positively to be dead, operation for emptying the uterus may be performed. The question of the presence of life, and of the necessity of removal of the reproductive organs or interfering therewith, by surgery or medicine, must in all cases be determined by previous competent consultation.

14 Unprofessional and unethical conduct and violation of the surgical code of this Hospital and of the rules of this staff shall constitute a cause for expulsion. Any member against whom such charges have been made shall have the opportunity of appearing before the advisory board in his own defence before final action shall be taken.

15. It shall be the duty of the staff to aid in the educational advancement of its interns and nurses to the fullest extent.

16. Duties of interns and nurses and their relations to the hospital and staff shall be prescribed and controlled by the advisory board.

17. The following orders of business shall be observed at regular meetings:

1. Call to order.
2. Roll call of members.
3. Reading of minutes.
4. Unfinished business.
5. Reports of Committees.
6. Communications.
7. New business.
8. Election of officers.
9. Presentation and discussion of cases, reading papers, etc.
10. Adjournment.

18. **Rules Governing Election of Officers.** Any five members of the staff may nominate candidates for any or all offices by submitting the names over their signatures at any time prior to the regular February meeting of the staff; nominations to be sent to the hospital office. All nominations will be read at the February staff meeting, and thereafter posted in the record room of the hospital till the March meeting at which time election will be by written ballot.

The one receiving a majority of all votes cast shall be declared elected. If no one receives a majority the one receiving the lowest vote will be dropped and another ballot cast till the majority is gained by one candidate. In case of a tie vote lasting through the second ballot the two candidates shall cast lots for the choice.

19. **Robert's Rules** of order shall govern all meetings when consistent with the by-laws.

20. **Quorum.** A quorum shall consist of a majority of the members of the staff.

21. **Amendments.** Amendments to this constitution and by-laws may be made by submitting proposed amendment in writing at a regular meeting at which time it shall be read and inserted in the minutes.

At the next regular meeting it shall be taken up under the head of unfinished business, and shall require for adoption a majority vote of the members of the staff. Amendments thus adopted shall go into effect on receiving the approval of the Sister Superior of the sanitarium.

The Elements of Hospital Success.

Other hospitals in putting into effect similar regulations have experienced certain difficulties. Sometimes it was the doctors who took the lead and they had their troubles in getting the hospital management to do its part. In certain places the doctors have taken the initiative, and in doing so have gone so far as to equip a laboratory and employ a pathologist in order to do their

work as it should be done. In one hospital in San Francisco the doctors pay the stenographer who takes down the history of the patient as dictated by the doctors.

Fortunately, in this hospital all these facilities have been provided by the Sisters. Even at this time, two months before the whole plan goes into effect, the record room is in operation. There the doctor may go and dictate his histories. Miss Louise Jenks, the historian, takes dictation directly on the typewriter. This is of such a decided advantage that the doctor may dictate the history, make corrections or additions as needed, and have a complete typewritten history in a very short time.

The success of our program depends upon whole-hearted cooperation between all parties concerned. It means that we doctors must get out of the rut of indifference. Too often the truly wonderful spirit of our profession is crushed, deformed, and twisted into the monstrosity—commercialism. When mutual helpfulness and good-will take the place of selfishness, egotism and distrust, then progress will thrive. A hospital staff must be loyal to the hospital, and loyal to one another.

A great deal can be accomplished if each member will whole-heartedly interest himself in this undertaking, which unquestionably is for the common good of all. Gentlemen we must accept this movement, and we must abide by its principles. It is being thrust upon us, if you please, not by the hospital, not by any reform organization, but by an awakened public conscience; consequently it is irresistible. It has required, and will continue to require, some wholesome education among the doctors. It will require work on the part of all, but as time goes on the benefits to the patient, the hospital, and the doctor will be abundantly manifest.

Conservation of Health in Religious Communities

By a Hospital Sister

IN a recent number of "HOSPITAL PROGRESS" appeared a very timely and well written article which will find appreciation in the hearts of many religious throughout the country. I refer to the article entitled "The Need of Sanatoria for Tubercular Religious and Clerical Students," by Doctors Nagelman and Burkhart of California.

The authors have pleaded so well the cause of the tubercular religious that no further comment is necessary, but perhaps a few words on a closely related subject will not be amiss. In view of the scarcity of institutions where sick religious can be properly cared for, it appears to be the duty of well religious to do their utmost to preserve their good health and, if they are superiors, the health of the Sisters under their charge. If this important matter is attended to, the various religious communities will not have so many subjects for tubercular sanatoria, and will have fewer deaths among their number from tuberculosis and other curable and preventable diseases.

It is sad enough to see a young and useful Sister die of tuberculosis because, having once contracted it, she had no opportunity to obtain the necessary care and treatment. It is sadder still to see Sisters "shelved" after a few years of ambitious hard work for their communities, either because their negligence in matters of caring for their health has led them to fall victims to some preventable disease or, as sometimes unfortunately happens, because they have fallen victims to a hastily-made and incorrect diagnosis and have to suffer the consequences. The writer feels that there are many religious throughout the country who have had this unhappy experience and feels a keen sympathy for them.

When you look at the list of Sisters who have died since you entered your community, you can ask yourself how many of those deaths could have been prevented. How many Sisters died of tuberculosis? How many of these could have been cured if the necessary facilities for treatment had been available? How many died because a wrong diagnosis had been fastened on them, and after a few miserable years of discouragement and half-hearted treatment, they finally succumbed to the desire for death? How many died of preventable diseases which were brought on as a result of overwork, irregular hours, and nervous strain? How many who died young would have lived long and useful lives if they and their superiors had paid more attention to the fundamental laws of health? Surely hospital Sisters, more than any other class of people, should know how to take care of themselves and to avoid the occasions of disease. Yet the deaths among them are out of all proportion to their number. This is altogether unnecessary and wrong, in an age illuminated so brightly by the light of science, an age in which the means for the prevention of disease are a matter of common knowledge.

Recently the writer was visiting one of the largest Sisters' hospitals in the country, and supposedly one of the most progressive, one in which are employed a very large number of Sisters, who apparently had every means of doing their work with the maximum of efficiency and of conserving to the utmost their own health and strength. One of the Sisters in this hospital gave the information that hardly a single Sister, in all the large number employed in the hospital, was in good health. All were suffering from some complaint or other, and in the majority of cases these complaints were due to some preventable or easily curable disease, or to some defect or injury sustained in line of duty and which could be easily corrected surgically.

It may be said that this condition arose from the fact that the Sisters were so overworked that they had no opportunity to go off duty and have these things attended to. However, it seems that with a little management and a little more cooperation between the Sisters and their Superiors in this matter, a better condition of things could be brought about. It is a matter of the adjustment, not only of the individual's point of view, but of the point of view of the whole community.

To illustrate my meaning: We may be overworked, or at any rate we may think we are. If we are not able to do everything that is assigned to us, on account of physical disability, we must do the more essential things and leave the less essential things undone. Therefore it is a question of: what are the essential things? Everything connected with the proper care of our patients, of course. But in order to care properly for our patients we must be physically fit. Therefore that is an essential. If we are not physically fit, we must, for the sake of the sick to whom we have pledged ourselves, make ourselves fit as soon as possible, even if we have to go off duty altogether for a while in order to bring this about.

Again, the very fact of our being overworked is due in very many cases to the fact that our work has not been systematized as it might be, and that we are wasting the energy in our heels by not utilizing that in our heads. In the modern hospital, where we have almost every convenience and help in the line of mechanical contrivances, very few Sisters are so overworked that they cannot attend properly to their health. Attention to the fundamental laws of health takes a good deal less time than a good many things we do to the detriment of our health, and all of us, if we make up our minds, can devise a method whereby we can give our health the necessary attention.

It appears to the writer that this matter of keeping Sisters in good health is one which Superiors can do more to regulate than any physician, but it is one which demands the utmost tact, finesse and prudence on the part of the Superiors. If a Sister in charge of a house is sensible and tactful, she can keep those in her charge healthy and happy.

In the matter of caring for sick religious, Doctors Nagelman and Burkhart have brought out the point of lack of authority on the part of physicians who may be called. If this matter could be adjusted, the idea of a full-time physician for large communities would work excellently. But as long as the physician is in the dark concerning living conditions, and without absolute authority in regard to the regulation of these conditions, his work must of necessity be ineffectual.

I realize that this matter is not in the hands of the Superiors alone. The Sisters themselves must cooperate. In many cases it is a task of the utmost difficulty for Superiors to force the Sisters under their charge to take the proper care of their health. But there are also some cases, although they are comparatively rare, in which Sisters are allowed to work beyond their strength until their resistance is broken down and they become victims of tuberculosis, chronic heart or kidney disease, or other preventable or curable diseases.

Most young Sisters are ambitious and inclined to work beyond their strength. If their ambition is not wisely restrained they will begin to show the logical results of overwork and waste of energy. On showing symptoms of illness they are often treated by a physician who is probably not familiar with all the conditions bearing on the case; he is probably also pretty busy, and perhaps the Sisters are taking a great deal of his time, and he does not go into the case very thoroughly. As a result he may make a hasty and incorrect diagnosis. If this diagnosis is, for instance, tuberculosis, the lack of facilities for care leads the community to give up the sick Sister as doomed, and she lingers on for a few years in discouragement and hopelessness, as far as a cure is concerned, and finally another name is added to the already long list of unnecessary deaths. Or if the diagnosis is any one of a number of other curable diseases, the result may be the same. Although, of course, a number of these diseases can be treated at home, without any need of sending the patient to a sanitorium, still we have the drawback of limited facilities, and the element of discouragement in the patient, especially and above all if the diagnosis has been incorrect.

Sometimes we come in contact with certain Sisters in our communities who are considered "not very energetic," etc. It may be vaguely surmised that these Sisters are suffering from some grave disease, but since "nothing much seems to be the matter with them," no one pays any attention, until finally their death reveals the fact that they had suffered for years from a disease which, neglected, became mortal.

Another condition which is not as it should be is the difficulty under which sick Sisters labor when they find it necessary to try to regain their health without leaving the hospital where they are on duty. Many times when a Sister is suffering from a supposedly slight ailment, it is not considered necessary to take her off duty, and she is told to "rest and take it easy." This is all very well; but how can a Sister "rest and take it easy" if her community is short of Sisters and she knows that if she is unable to do her work it will go undone? And anyhow Sisters are so constituted that in most cases such vague admonitions will be of no benefit. The situation requires more drastic methods. And again, if a Sister is unusually sensitive during her illness, she will prefer to work to the utmost of her strength and beyond it, rather than be the object of the unsympathetic comments of others who may not understand her condition. She will not wish to be a burden on the community; she will not be willing to

leave her work for some one else to do. In these circumstances, only the sympathetic good sense of a tactful Superior can right things again.

Every Sister who has given any thought to the matter, or who has had any experience along these lines, knows that after a certain period of overwork, irregular hours, or nervous strain, (of which latter many varieties can be met with in the religious life), a train of symptoms may appear which may simulate tuberculosis or heart trouble or any one of several other diseases. If only superficial care and observation is given to these cases, the Sisters may become chronic invalids without any necessity whatever of their being so. If these cases, on the other hand, are handled intelligently, by a physician who could have a complete insight into the true state of affairs, a cure could be effected much more speedily than is the rule at present. Many times when a physician is called in to care for a sick Sister he has to fight in the dark: there are many conditions having the most intimate bearing on the case, and of which he can know nothing: and these are not always mere living conditions either. Even if he has a glimpse of these conditions he is powerless to remedy them. Who can expect him to do effectual work under these circumstances?

The importance of the power of suggestion is as apparent here as elsewhere: perhaps even more so in the religious life, where the lack of those outlets for energy and emotion, that are accessible to people in other walks of life, tend to foster introspection and the manufacture of mountains out of molehills. This makes it all the more imperative that Superiors should know how to make Sisters see the relative importance of things, and by wisely restraining some in matters concerning health, and spurring others onward, preserve the balance of power, as it were.

It may be considered the highest form of unselfish devotion on the part of hospital Sisters to neglect or lose their health while caring for the sick. This is, nevertheless, a wrong attitude. It really is poor religion as well as poor economics, not only to neglect to provide for sick Sisters, but to neglect the conservation of the health of those who are well. Sir George Newman says that the primary purpose of medicine is not to cure but to prevent disease. Certainly then the prevention of disease is as important as its cure. Good health is one of the greatest of blessings, and it certainly appears logical that its abuse will be followed by punishment. Furthermore, to elaborate a point mentioned previously, we have pledged ourselves to the care of the sick throughout our lives: and are we not robbing the sick of what we owe them, by destroying our health and unfitting ourselves for our work? And is it becoming for those pledged to poverty to waste and destroy, knowingly, that most precious of all commodities, our health and strength? Food, equipment, and the community's goods, when wasted or destroyed, can easily be replaced: but the health and strength of the Sisters can never be replaced. These considerations should have more weight with Sisters than they do. The exalted virtue of consistency, and the ability to see the relative values of things, will be most useful here: religious are often inclined to magnify unduly the importance of delinquencies much less grave than these.

Sisters Superior reading this article will no doubt call to mind many cases in which Sisters under their charge have been very difficult to deal with in regard to treatment and care in illness. It is unfortunately the case that many Superiors who are eager to do everything possible for the health of their Sisters are met by almost unconquerable opposition on the part of the Sisters themselves. Some Sisters will persistently overwork unnecessarily, and in disregard of the express directions of their Superiors. Others will abuse their health in other ways: for instance, by staying up at night to finish work which by a little more systematic management could be attended to during the daytime; others will deprive themselves of the necessary nourishment with the excuse that "they have not time to come to meals," when the truth of the matter is that their hurry is all due to lack of system in their work. And most exasperating of all, some will persistently refuse all treatment and care for those illnesses which they have brought upon themselves, until it has to be forced upon them, when, of course, they lose most of the beneficial effect it might have had.

In every religious community, as in other walks of life, we find a number of neurasthenics, who are constantly occupied with their latest diseases, and who feel much injured if they consider that they merit more sympathy than they are getting from their Superiors. To deal with these successfully requires a great deal of shrewdness and finesse, and in the long run it is the Superior who has the greater part in shaping the outcome of these situations.

It may be considered a praiseworthy thing for Sisters to forget themselves and their health in the service of the sick. It may be, if they are compelled by circumstances to neglect their health. Nowadays, however, such sacrifices are not often required of us. If we had given our lives in France or Flanders, or spent ourselves at the time of some great public calamity, we should deserve to be equally honored with the warrior dead: but in our comfortable hospitals, where conditions are for the most part such that it is easy for us to keep well, and the risks are but slight, it is no virtue to throw away the precious boon of health. It is very edifying, no doubt, to gaze upon the peaceful face of a dead Sister and to think on the unselfishness with which she gave her life for the sick: but God would rather, I am sure, see our hands busy with useful tasks than to see them folded in the stillness of a premature death, and He who judges justly will not deem it worthy of reward that a life which might be devoted to humanity has been thrown away.

This whole matter of the conservation of health in religious communities is one from which the cobwebs of tradition should be swept away and the sunlight let in. Physicians called to attend Sisters in illness should have a thorough knowledge of conditions and complete authority to act. Sisters Superior should do their utmost to make living conditions right, and to foster a cheerful, sensible atmosphere in convents. They should also strive to take just the right attitude toward Sisters who are sick, whether it be sympathy that is needed, or a wise restraint in the matter of overwork, or the regulation of hours, diet and habits generally. The Sisters themselves should help to lighten the Superior's burdens by using common sense in regard to their health and the conservation of their strength, and by giving the necessary attention to those fundamental laws of health which are so easy to practice. And all together let us work for the day when, owing to our united efforts, not only curative medicine, but preventive medicine, available to all, will lower the death rate and the incapacity rate in our communities.

The Patient's Viewpoint

Paluel J. Flagg, M. D., New York, N. Y.

(Conclusion)

ALPHA AND OMEGA.

AMONG the lay professions, we seek in vain for one which can be compared with the practice of medicine for its pure altruism; its self-abnegation; and its lofty idealism.

The sworn enemy of death and its advance guard disease, it fights its ceaseless war with a persistency and optimism worthy of eternal issues. Everlastingly youth is hers, for she sees in her failures her successful goal.

Where may we find a profession which will strive whole-heartedly through centuries to attain an end which when achieved will extinguish its possessor? For the elimination of disease means the elimination of the physician, at least as we know him today.

We seldom think of the physician as constantly laboring to undermine the source of his income. Yet such is the case in its last analysis.

We see in the life of the profession the motive force of the spiritual and the purely material, energizing its activities. Let us follow each to its ultimate conclusion. Let us imagine the world of medicine actuated by motives entirely free from the supernatural.

A new era has arrived in the evolution of the human species. The dangers of pregnancy can easily be avoided by simple remedies, for sale at any subway slot machine. Parents who find that they have a sufficient number of children and who have neglected the usual prophylactic precautions may go to the registered abortionist who will curette them for a nominal fee. The race is never more to be hampered by the burden of poorly developed or defective children. If the newly born does not thrive and the mother is disinclined or unable to rear it by artificial feeding, she may arrange upon the payment of a small sum to have it called for and carried to the parlors of extinction, where a painless death is guaranteed.

We no longer find the hospital beds encumbered by the chronic invalids. Cases which have been demonstrated as incurable are made aware of their hopeless state and seldom refuse to take the usual lethal dose of nitrous oxide. Consider the signal advances which we have made since the period when it was considered good surgery to do a mutilating operation for a cancer or to apply radium for long periods. Think of the pain which those patients and their relatives were forced to undergo and compare this with our present method of painless extinction. And then, too, observe the marvelous advances in surgical technique, particularly as regards brain surgery. There was a time when this work was limited entirely to animals. Since the establishment of the "New Institute for the Localization of Sense and Idea Preceptions," all this has been changed. Convicts condemned to death, the mental defectives and cases with incurable malignancy supply us with exact material for research, which it was impossible to secure in the olden times.

The mobile extermination unit is as common on our streets as the old-fashioned ambulance used to be. The new Vita meter which accurately determines the probable duration of a patient's life is always available. It is quite reliable, only a few emergency extinctions having been reported as errors.

Radical changes are also to be seen in the hospital field. Institutions controlled by religious no longer exist for the simple reason that now no one is so absurd as to give up his life for a hereafter, whose very existence has been disproved. Homes for the aged and infirm as well as orphanages have disappeared. How simple life has become. We may now demonstrate its destiny in its fullest growth and greatest activity. The medical problems which we have been unable to meet, we have suppressed by extinguishing their possessors. This has been effective and satisfactory. The physician who is rightly proud of his achievements, may if necessary, back this up by the splendid physique which he possesses. If he covets the work of another man with whom he is competing he is at liberty to do so and to use any means which his ingenuity may suggest to acquire that which he wishes. Should he take a sudden fancy to a woman under his care, he may take

any liberty which suggests itself to him irrespective of the existence of her husband, provided he is discreet and is in a position to defend himself, if exposed. The anger which he may feel if provoked by another's criticism of his work, is a manly attitude and retribution is incumbent upon him. It is perfectly natural that he should envy keenly the wealth and the mental qualities of those who have been more successful than himself. And should success some day become his, what is more natural than that he should drink until he is unconscious and eat until distressed and that he should spend the remainder of his days in sweet idleness and sleep.

Pure science cannot lift itself by its own bootstraps. It may become developed to a hitherto undreamed of degree, but it can never change its intrinsic nature. Such is the ultimate destiny of the atheist.

See on the other hand the sweet, deep undercurrent of the spiritual; activating, maintaining and developing the practice of medicine as we are accustomed to look upon it.

The fundamental object of medicine is to make the body a fit place for the residence of the soul. To prevent and cure disease so that the "man" may be able to do his best work. By recognizing the presence of the spiritual tenant medicine is permitted power over it. By denying this presence, she denies herself this power and the intimate control which it exercises over the physical functions.

It is the tacit admission of the presence of the soul through many generations of ancestors which permits of an unconscious respect for this principle in the minds of those who are now avowed atheists. Christian civilization has impregnated men's minds with spiritual motives through the centuries. So that when we find the materialist possessed of humility, with a liberality towards others and an inherent respect for the women whom he treats, when we see him meek in the face of irritation, temperate or even abstemious in habits, when we see him giving the other fellow a helping hand, irrespective of any thought of reward and when we see unrelenting diligence in the presence of all that money can buy, we conclude that these qualities are the fruit of the practical Christianity which this man's ancestors once possessed. We see this man's personal decadence in the midst of his inerited worth, because he fails to grasp the ordinary arguments which prove that God exists. Let us reflect upon the reasons which we have for believing in the existence of God.

First of all, we have the universal law of motion. Physics and chemistry have pointed out to us the universality of motion. The molecular motion of the primary elements ranging from the slowest vibration of metals through sound, heat, light and X-ray. Our mental processes also indicate motion not only as oscillations of Nissel's granules but as the exercise of a function. When we think of motion we may think of movement in a direction or a change of state. There must be an initial point of motion and a primary stage. The change from this initial point and primary stage must have come from an extrinsic source which was itself immovable. This source or prime-mover was the Creator.

The principle of casuality affords us a further reason. If we give a man repeated doses of morphine, we know that in time he will become a morphine habitue. On the other hand, we know when we meet an addict that the cause of his condition was the repeated doses of morphine. The giving of the drug was the cause, the malady was the effect. As the man's condition did not come first and his use of drugs second, we observe a definiteness of direction, of cause to effect. Furthermore, the cause and the effect did not occur, as a mere sequence of events, since the cause furnished the reason for the effect. Our researches have established an underlying unity and order in the causes and effects which we see in medicine. Moreover, we perceive that in addition to the universality and order of cause and effect, there is actually a transference or giving of something by the cause to the effect. Or in other words, the cause contains within itself the essence of the effect.

If we will look about us we will see that nature, the universe, exists, as we know it, through the all pervading orderly play of cause and effect in a definite direction. As the series of cause and effect in nature cannot be infinite we must finally arrive at the First Cause, who as has been shown, must contain within itself the essence of all its effects. It must be the essence of all power, goodness, and intelligence. This first cause is God.

Furthermore, we find that the conception of God is a necessary truth. We know that there is a wide difference between the ways in which things are felt to be true. For example, in the time of Pharao, the builders of the ancient sphinx made their mathematical calculations upon the same basis as we do today. Three plus three meant six, in the same way as they do today. We cannot conceive of three and three ever meaning anything else but six. This is a necessary truth, it always has been, is and always will be. We can imagine, however, that the sphinx might not have been built or that Napoleon might have been victorious at Waterloo, or that we might have attended some other medical school. These truths are spoken of as happenings or contingent truths. Necessary truths do not depend upon extrinsic causes for their existence, they contain the cause. Contingent truths do depend upon extrinsic causes or determining factors.

To what class of truths does the universe belong? Clearly to the class of contingent truths. For it is obvious that the universe did not always exist, and if

so, it is conceivable that it might never have existed. We are forced, therefore, to conclude that its existence was brought about by an extrinsic influence. "For true science asks the causes of things and takes as its ruling principle that nothing happens by chance." To ascribe effects to non-existent causes, is to practice the grossest superstition.

"The argument may be summed up by saying that our reason, by refusing to confuse the things which it feels, must be, with those which are, but might not be, has a sense of necessity. It thus enables us by demarcation to perceive the quality of contingency, or non-aseity; in other works of createdness, which attaches to the universe whether in its constituted parts or its constituted whole. As such a universe must have for its existence a determinant which is not of itself, there must exist outside of it a Being, self-existent and necessary, upon which it depends. This being we call God."

The idea of perfection sustains the reason which we have found in motion, causality and necessity. Perfection means completion, consummation, wholeness. The diagnosis which we make, the surgery which we do, the cures which we bring about, all possess their elements of error, they but approach perfection. When we compare the mineral, vegetable and the animal kingdom with man we find relative perfection. And as we are well aware man is not perfect. And so, we see relative worth a universal characteristic. A fact which is relative, is so by virtue of its implied comparison with the absolute. For a relative without an absolute is unthinkable. Absolute perfection is but another name for God. To insist upon the relativity of all knowledge is to exclude altogether absolute knowledge. In other words, it is to remove all the security which we place in our exact knowledge of facts. Furthermore, to insist on relativity is to support the contention of the presence of the absolute, the all perfect God.

The appeal made by the argument of design is readily appreciated by the medical mind. Were a stranger from some distant planet to drop from the skies and view, with an intelligent eye, the Queensborough Bridge, the elevated structure, or the grouped office buildings of Manhattan, he would be forced to conclude that they did not occur spontaneously, that they were the crowning achievements of an intelligence or a group of intelligences, and that they were necessarily conceived before being constructed. How, then, can we, in viewing the solar system, the life of a plant or the organized community of a beehive, refuse to see the evidence of an intelligent design. How can we look upon the amazing complexity of the human organism and fail to appreciate the marvelous harmony of organic function. We strive to understand the minute details of the respiration, of digestion, the circulation, the gastro-intestinal, and the genito-urinary tract, and when we have learned the histology, the anatomy, the physiology of man, we are content to leave him thus with never a thought of the meaning which lies behind the exquisite adjustment of the elements and organs which make up his being.

"Symmetry and construction are characteristic of nature. Man's machines are fitted together from the outside. Nature machines are fitted together from the inside and by the forces which permeate them. Self-adaptation and the transformism of evolution but confirms the presence of an all-directing intelligence. A blind force does not contain within itself the all intelligent design of the universe. An all-wise, all-knowing God is the only possible source.

Law and conscience support their origin. Our reason tells us that certain things are true or false. Conscience voices the conclusion of reason by dictating that a thing is right or wrong. This distinction we feel is not arbitrary or conventional but rooted in the nature of things. We know, for example, that three and three make six, that this truth can never be altered even by a solemn meeting of a league of nations. In like manner, there is a law of right against wrong, which in its ultimate principle is unmistakable. Reason may apprehend the existence of God in two ways—either by looking back at Him as the First Cause or looking forward to Him as the Last End. The one tells us that we were made by Him, the other that we were made for Him. It is out of this second or final perception—viz., that we are made for goodness, or for God as our end—that comes the judgment of reason of what is or is not in harmony with our reaching it, God's pleasure or displeasure, as we call it—and the sense of sin or justice with the practical "ought" or dictate which we name conscience.

The light of reason, in its true domain, and in its primary principles, whether turned backward to God as our first beginning in the revelation of our origin, or forward to God as our last end in the revelation of duty, remains the true Schekinah of the presence of God—the Alpha and Omega within us.

The ontological argument will appeal to those of us who are of a philosophical turn of mind, the ontological proofs of the existence of God are generally felt to be abstruse and profound and require philosophical training for their proper appreciation. The argument revolves about being as contrasted with nothingness. It is adduced that being is not only necessary but eternal, infinite, one and immutable. A bridge between the ideal and the real is discovered which is found to substantiate the argument of design.

It is in His absolute and transcendantal unity containing the reason of all things—and not in our poor fragmentary universe of things below—that we find the term of true monism with which our unity loving souls crave to finish up the synthesis of all that we are and all that we know. He is the Eternal Mono.

And lastly we have the appeal of the aesthetic. The idea and appreciation of beauty depends upon unity and variety. The most beautiful is that with the greatest variety, or muchness-of-being or wealth of formal entity.

The absence of unity is chaos. The mind itself is an active unity, active with the highest kind of life, which is intelligence. Intelligence is living unity with the power of reading unity and all things by their unity.

There is a very close connection between intelligence and appreciation of the beautiful. The conception of beauty is more easily recognized and relished the higher we ascend in the scale of the cultured and refined mind. If beauty be a hand-writing upon the open page of the universe which only intelligence can read, it must also be one that only intelligence can have written.

"All beauty is the appeal to our intelligence from the Supreme Intelligence—the Infinite, Whose Oneness is the source of all unity whether thinking or thinkable and whose fullness of being is the source of all wealth of variety. The beauty which we perceive is the shadow of the Infinite Beauty cast upon creation, and the only reason why one thing is more beautiful than another is because it has more of the joy-giving likeness of God."

We may then prove the existence of God through the fact of motion, casuality, necessity, perfection, design, law, otology, and the aesthetic. "But physical experience is naturally limited to physical phenomena and modern science does its work wearing spectacles which by their very nature cannot carry beyond secondary causes. To all the experience of sense-preception, the First Cause must remain invisible and inaccessible. God cannot be caught in the tests of the laboratory any more than He can be formulated on the blackboard. And that not because He is not, but precisely because He is, and is what He is and must be. A God that could be so detected by sense, or compressed into a finite formula, would be within measurable distance of us, and upon the upper end of the same intellectual plane as ourselves—He would certainly not be the First Cause, would not be the Necessary Being, would not be transcendental—all of which are but so many ways of saying that He would not be God at all. When, therefore, certain men of science tell us that in all their chemical or biological researches they have failed to find the faintest trace of a Supreme Being, we can only say that no one in possession of their senses ever imagined that they would or could, and that their testimony can only be welcome to us as their contribution, helping us in their way, to prove the transcendentalism, or what Scripture calls the invisibility of the King of the Ages—a quality which we feel to be one of the most necessary in the elements which enter into the concept of God.

It seems to be out of fashion now days to even allude to God or the spirituality of man. The man who opens such a vein of thought finds himself declasse. To think much on the supernatural is to know something of it. Knowledge, by the sheer beauty of the object which it contemplates, turns to love. Love for the spiritual creates a fire within its possessor which is its own energizer, consuming the base with which it comes into contact and giving rise to yearnings which can only be appeased by spiritual joys.

Science alone cannot alleviate our wounds. Science, the handmaid of the supernatural, glorifies itself by this betrothal and prepares the way to the rational relief of the abuses which perplex and destroy the ideal medical life of the individual and the institution.

GRADUATES, ST. JOSEPH'S HOSPITAL, LEWISTON, IDAHO.

SECTIONAL CONFERENCES
of Catholic Hospital Association of The United States and Canada

Southern States' Conference of the Catholic Hospital Association

The first annual meeting of the Southern States' Conference of the Catholic Hospital Association was held December 29-30, 1921, at Shreveport, La., with Sister William, St. Rosa Infirmary, San Antonio, Texas, presiding. At the meeting fifty-six Sisters, eleven nurses, nineteen doctors and six members of the clergy were present from the districts represented by the conference. Rev. C. B. Moulinier, president of the Catholic Hospital Association, who called the meeting to order, gave a short talk on the work of the hospitals and outlined a plan of administrative procedure for general adoption. The following officers and committees were selected:

President, Sister William, St. Rosa Infirmary, San Antonio, Texas; First Vice-President, Sister M. Raphael, Texarkana, Ark.; Second Vice-President, Mother Clare, Laredo, Texas; Third Vice-President, Sister Vincent, Dallas, Texas; Secretary-Treasurer, Mother Marie de Bethanie, Monroe, La.

Executive Committee: Dr. J. C. Willis, Sr., Shreveport, La.; Rev. T. A. Cronin, S. J., Shreveport, La.; Hon. Frank Looney, Shreveport, La.; Mr. Andrew F. Querbes, Sr., Shreveport, La., Mother M. Placidus, Galveston, Tex.; Sister Michael, Houston, Tex.

Committee on Information in Hospital Work: Chairman, Sister M. Elizabeth, Beaumont, Texas; Sister M. Elphege, Monroe, La.; Sister M. Celestine, Shreveport, La.

Committee on Laws for Hospitals: Chairman, Sister M. DePazzi, Texarkana, Ark.; Sister M. Elizabeth, St. Anthony's Oklahoma City, Okla.; Sister M. Ursula, Austin, Tex.

Committee on Cooperation with Hospitals Chairman, Sister M. Beatrice, Shreveport, La; Sister M. Sebastian, Beaumont, Texas; Sister M. Stanislaus, Charity Hospital, New Orleans.

Committee on Constitution and Bylaws: Chairman, Sister M. Edward, Hot Springs, Ark.; Sister Bernard, Little Rock, Ark.; Sister M. Presentation, San Angelo, Texas.

The following papers were presented at the conference:

INTRODUCTORY REMARKS

Rt. Rev. C. Van de Ven, Bishop of Alexandria, La.

IT is rather difficult for me to speak on an occasion and before an audience like this, being so little familiar with the subjects that will come up for discussion at this conference. I came here chiefly to show my interest in this great movement for the improvement and standardization of hospitals, a movement which is so fraught with great possibilities and in which the Catholic Hospital Association is taking such a prominent part. Not being able to say much that could be helpful to you, I might say something to please you, namely; that you are certainly a beautiful sight. So many of you who have come from near and far to gather here for this worthy and noble purpose, and that I admire your good taste and judgment in having selected Shreveport as the first meeting place for the great Southern Conference. I am sure that you are already admiring our beautiful climate as well as the beauties of the progressive city and the warm hospitality extended to you by the good Sisters of this institution. I am delighted to see so many of you here, and to see such a fine array of professional talent on the program, in spite of the very short notice given of this conference. I am pleased to see among the list of speakers the distinguished Vicar General of Galveston, whose presence will greatly help to make these meetings lively and interesting, and, above all, I am delighted to have here with us Father Moulinier, who is the inspiring and moving spirit of this movement. I am sure with his presence there will not be a dull moment during the whole conference and it is bound to be a great success.

It is but natural that we, the spiritual pastors of the Church should take a deep interest in anything that tends to improve our Catholic Hospitals; they are in the first place institutions of Christian Charity, and you, dear Sisters, in your ministrations to the sick and suffering are the representatives of Mother Church herself in her charitable activities, which are a chief part of our mission in the world, and by which she is chiefly known to be Christ's Own. You, dear Sisters, are concentrated in your work and in your efforts to improve its efficiency, not merely by the natural ambition of being proficient in your calling and enlarging the usefulness of your institution, but you are thereby living up to your Sacred Calling, and striving to serve Christ himself in the person of His suffering members. This being so, you have a higher motive in not only following, but even in leading in the movement for hospital improvements. Our Catholic Hospitals, which are the largest percentage of hospitals in the country, should be in the forefront, and be second both in efficiency and progressiveness, to none.

I, therefore, hope and wish that this conference will prove a great success, will give you occasion for discussion of many points of interest, will stimulate your desire for even greater improvements, and pave the way for the greatest and widest possible advance and progress in this great field where Science and Christian Charity work together for the relief of human illness and suffering.

ADDRESS OF WELCOME.

Rev. T. A. Cronin, S. J.

"Right Reverend Bishop, Reverend President, Doctors, Sisters and Nurses:

The lines of one of our great British poets may very aptly be applied to me in my duty as salutatorian on this occasion:

"Words are like leaves, and where they most abound
Much fruit of sense beneath is rarely found."

In compliance therefore, with the idea expressed by the poet, I will make my words of welcome as brief as possible. Shreveport is very proud of the honor conferred upon her. You have chosen our progressive city as the meeting place for the first annual Conference of the Catholic Hospital Association. We are glad, very glad, to have you. You have come to the most prosperous,

most progressive city in our Southern States. You have come to a city that is known throughout the country as an oil center second to none, you have come to a city that is forging steadily forward with a constructive program surpassing anything of the kind in the entire history of the Southland. Despite the trying financial situation throughout the nation, brought about by the readjustment process following the world's greatest war—and while other cities more pretentious than ours are struggling to hold their own; with gigantic strides, Shreveport is pushing to the forefront. Therefore it is that we are delighted to be the proud possessors of this First Annual Conference. We are glad to have you this morning, and we feel confident that your visit to our city will not soon be forgotten. We bid you a hearty welcome."

GREAT WORK OF THE CATHOLIC HOSPITALS.

Rev. C. B. Moulinier, S. J., President Catholic Hospital Association of the U. S. and Canada.

WE have, he said, on this continent 674 Catholic hospitals attended by over 20,000 Catholic sisters and 25,000 lay nurses. To these hospitals in the course of one year, come over four millions of patients! The enormity of this is overwhelming when we sit down and ponder that that great work, unnoticed, almost, is in reality one vast religious act, participated in by every one associated in the work. Rarely, if at all, do those who carry on the work consider the great reservoir of spiritual results and benefits accruing to those engaged in it. These things are rarely if ever referred to.

If we consider, on the other hand, what evils are prevented by hospital standardization, as it is at present, we can form an idea of the good to be brought to the people of this continent by its development.

The first result is the prevention of from 20,000 to 30,000 unnecessary operations. From 15,000 to 20,000 criminal operations, can be hindered or prevented, and 600,000 average yearly operations performed with vastly more care and better results. From these figures we can form some idea of the necessity for the subject being taken up in a systematic, scientific manner by all interested in human welfare.

The basis of these results is contained in the understanding and appreciation of Catholic ethics. The non-Catholic is guided mostly by natural laws, imperfectly understood. We have an infallible teacher. Two rules we set ourselves to get universally accepted will go a long way to accomplish the end we have in view.

The first of these is preoperative diagnosis.

The second is, that all tissue be sent to the laboratory.

These two laws we hope to have in operation before the end of the year, and by an intensive campaign through the Catholic Hospital Association, now being formed throughout the United States.

The Catholic Hospital Association in forming its own standards, and carrying them out in a scrupulous manner, will not interfere in any particular with the American College of Surgeons, but will rather add to or lift the standard of the American College to a higher plane of usefulness.

In striving for the ideal it sets itself, the Catholic Hospital Association has one slogan—the best.

Proposed Administrative Program.

Father Moulinier then outlined the administrative program the organization sets before itself for general adoption. He divided the program into four heads:

Complete records—clear, true, definite scientific.

Laboratory service—adequate, dependable—up to date—approved—the best.

Minimum requirements for efficient service.

No division of fees.

In elaborating each division, Father Moulinier went into many details.

Under the heading of Complete Records, he showed that what seems in many instances, to nurses and not a few doctors, to be an unnecessary expenditure of energy and time is in reality of the very essence of medical progress. "We cannot get anywhere without true, accurate records," he said.

Under the head of Laboratory Service, he outlined the advance that has been made in medical science. Many developments are purely experimental, and no hospital would dream of their adoption. What he wanted was that each hospital should have the ambition to install every new development in medical science that has been tried and found good for mankind.

He coupled with this the third division, namely, the minimum requirement, and said that if a hospital is unable to have everything first class itself, it should cooperate with another hospital so that the best would be available for the patient.

Discussing the division of fees prevalent in some parts of the country, he said it was repugnant to his nature to speak of it because it was really a trading in poor humanity, but that it must be eradicated from the profession of medicine before adequate and sincere service is received by the patient. The College of Surgeons is working against it, and the Catholic Hospital Association will work against it.

Father Moulinier said that he might add a fifth division to the administrative program, namely, the necessity of an autopsy, but suggested that was work more for people on the outside. At present, arrangements were easy in most centers for an autopsy where the cause of death was doubtful. The opposition usually came from the patient or the patient's friends. He suggested a publicity campaign through the public press, or at least through the Catholic press of the country, pointing out the service to science and the duty of mankind in such permissions. From every point of view it should be dealt with, but particularly the religious aspect, as he found that was where the chief objections lay.

ADDRESS ON BEHALF OF THE HOSPITALS OF NORTH LOUISANA.

Dr. J. C. Willis, Sr., Springfield, La.

I FULLY agree with what Father Moulinier has said in regard to the Sisters, for I am glad to say that I have been associated with them in their hospital work for a number of years, in fact ever since they have been engaged in this line of work in our city. I am especially glad to meet so many of them here on this occasion.

In behalf of the hospitals of North Louisiana I wish to bid you welcome. In the first place we wish to thank you for choosing our state for the first meeting of the Southern Catholic Hospital Association and especially that you chose North Louisiana and one of our own institutions for this honor. It is only within the past few decades that the medical profession and the public has had the benefits of a real hospital. In fact, it is in comparatively recent years that we can boast of real scientific medicine.

The history of medicine consists of three great periods. The first was the period of myth and fable and Aesculapias was its prophet. The second was the period of Hippocrates, the father of medicine, so called rational medicine, but in reality empirical medicine. While during this period, real scientific medicine and surgery were only made possible in the latter part of the last century by the work and achievements of the French chemist and scientist, Louis Pasteur and the famous English surgeon, Lord Lister, who by their labors, revolutionized both medicine and surgery and made the modern hospital possible.

I remember quite well some thirty years ago when I was a medical student, that our professor of surgery, who was then President of the American Surgical Association, and stood in the very front ranks of the profession, made the assertion quite frequently to his classes and in his clinics that he had no sympathy with the new-fangled theories of surgical infection and that personally he had just as soon have a poultice for his surgical cases made of micro-cocci and the rest of the cocci as of flax-

seed. He was so thoroughly imbibed with the teachings of the day which believed that pus infections were the inevitable result of practically all open wounds and not caused by the suppurative processes, and so you can imagine the kind of hospitals we had in those days.

I wish again to bid you welcome and express our thanks and appreciation of the pleasure and honor of having you with us.

The Work of an Up-to-Date Hospital Laboratory

F. G. Ellis, M. D., Shreveport, La.

All of you, no doubt, are aware in a general way of the work of a hospital laboratory, but there may be some that are not acquainted with the inner workings of a laboratory and therefore, I consented to prepare this paper to read today. Other hospital laboratories may have more elaborate systems, but the one in use here has been found suitable to our requirements.

On admission to the hospital the patient, if he pays room rent in advance, pays also a laboratory fee of five dollars, which fee goes to the laboratory. There are three classes of patients which are exceptions to this rule:

1st. Railroad patients.

In this class the hospital and laboratory each make their own arrangements with the railroad to take care of their employes.

2nd. Tonsillectomy cases.

As a rule these only stay one day, there is no necessity for laboratory examinations; however, if complications arise and they stay more than one day the fee is collected.

3rd. Obstetrical cases which come in for confinement only.

Even a urinalysis is unnecessary and unreliable.

It is really best to collect this fee on admission; but there are instances where it is good policy to leave it until the patient is discharged. This fee entitles the patient to any and all examinations requested by his physician, and these examinations may be repeated as many times as the physician deems necessary.

There is a standing order on all floors to have a sample of urine collected and sent to the laboratory, as soon as possible after admission if any emergency case, or if not, then a night sample is collected and sent to the laboratory next morning.

For the convenience of attending physicians in ordering examinations, requisition forms are kept on each floor on which are printed the names of the various common laboratory examinations so that the physician has only to check off the examinations he wishes and fill in the patient's name and room number, date and disease suspected.

Right here I wish to say that the laboratory clinician always likes to know part at least of a patient's history. Some physicians are loath to give this for some reason.

It would be tiresome for you should I enumerate all the examinations carried on in the laboratory, so that it is understood that all the common routine examinations are done in any place that calls itself a laboratory. I will therefore only take up some of the more complicated examinations.

Samples of blood for Wassermann are each subjected to three tests and results checked one against the other, so as to lessen the danger of error. Complement fixation tests for gonorrhoea are also done on blood serum.

The subject of blood chemistry is one that has made considerable advances during the past few years, and I think we should make ourselves better acquainted with it and for the benefit of the patients, make use of the valuable information it affords us. There is no branch of medicine that cannot gain a truer insight into a patient's condition by its use.

For the internist there are his heart cases, primary or secondary to renal conditions, nephritic cases, diabetes, acidosis, pancreatic diseases, these all show changes in the blood which can be determined chemically and with the added knowledge, treatment is instituted with a better understanding of the patient's condition.

The surgeon, instead of relying on urinalyses to indicate kidney function, can far better judge his operative risk with the additional information as to his patient's blood sugar, blood urea, uric acid and creatinine.

Then, aside from this preliminary survey of the operative patient, an acidosis may come on after operation, why not be prepared for an impending acidosis by knowing your patient's alkali reserve? In fact some authors go so far as to state that a great many deaths from so called sepsis are in reality deaths from acidosis.

The pediatrist with his diarrheal acidosis of infancy is benefited by the added information that blood chemistry gives.

The urologist may also gain important information as to the kidney functions of his patient.

While there are some seventeen chemical determinations which can be made on the blood, there are only seven or eight that are necessary for all practical purposes. To enumerate: Hemoglobin, Uric Acid, Urea, Creatinine, Sugar, Chlorides, Alkali reserve on Hydrogen iron concentration and alveolar co-tension.

The following normal amounts occur in the blood:

Creatinine 1-2 Mg. per 100 cc.

Over 3.5 Mg. gave prognosis.

Over 5 Mg. early fatal termination.

Urea N 12-15 Mg. per 100 cc.

Sugar 06-12%.

Uric acid 2-3 Mg. per 100 cc.

Alkali reserve gives a reading of about 8.5.

Chlorides .4-.5%.

The following conditions indicate these blood determinations should be made:

Diabetes—Sugar, alkali reserve. Urea.

Gout—Uric acid, urea.

Nephitis—Uric acid, urea, creotinine, alkalin. Reserve Chlorides.

Pneumonia—Urea, alkali reserve.

Acidosis—Alkali reserve.

In the conditions mentioned the various determinations show the following:

	Urea	Sugar	Creotinine	Uric Acid	Chlorides
	Mg. per 100 cc.	Pct.	Mg. per 100 cc.	Mg. per 100	As NaCl.
Diabetes (severe)	20	.20-1.2	2-4	4-10	.4
Gout				4-10	
Nephritis (acute)	.40-100	.12-.18	2-6	5-15	.45-.6
Nephritis (terminal)	60-300	.12-.24	5-28	5-27	.36-.60

Acidosis. According to the degree the alkali reserve gives lower readings. The more severe the acidosis the lower the readings, (Normal 8.5).

Chemical determinations on blood require about 10 to 20 cc of blood and must be made within 24 hours of the time the sample is collected.

The samples are best taken before breakfast.

A number of these tests may be made on the urine as well as the blood, for instance, Sugar, Urea, Uric Acid, Creotinine.

These are just a few facts that I bring for your consideration and to endeavor to stimulate your interest in this newer branch of science.

Cases for blood transfusion require donor's blood to be typed and this is comparatively simple.

Beside the simple culture and stain for organisms in the spinal fluid, cell counts are made, increase or decrease of globulin and sugar content are noted, Wassermann, Lange's Collodial gold test are done also on spinal fluid.

Usual routine analysis of gastric content after test meal is also made.

Examination under the dark field miscroscope of the serum obtained by scraping suspected syphilitic sore for spirocheta pollida is interesting.

Of course autogenous vaccines for various acute infections are made and either administered by us or by the physician in charge. The culture media necessary to make these vaccines and for other culture work is also made in our laboratory. We have now a standing order in the operating rooms of the institution that all specimens removed by surgeons by operation are to be sent to the laboratory. Bottles with formaline solution in them are kept in the operating department, already labelled for the smaller specimens. All the nurses have to do is to fill out label with name and room number of patient and bring bottles together with operative sheet to laboratory. A copy of this operative sheet or of such parts of it as are necessary to the laboratory is copied on the regular laboratory report forms and the operative sheet returned the same day to the patient's chart.

If there is reason for haste or if the surgeon requests it while patient is still on operating table, frozen sections are made and stained and reported immediately. If only a part of the regular routine, portions of the tissues removed are put through the paraffin embedding method, which takes much longer time but gives much better and thinner sections than freezing. With the exception of bone specimens, which take six weeks to decalcify, these reports are made once a month.

Just here I want to make a plea that surgical cases should be in the sanitarium at least a day before the operation, in order that the patient may be properly prepared and all necessary laboratory examinations completed before the time of operation.

Forms for reporting laboratory examinations are only two in number both being white paper. Some places use elaborate various colored paper for reporting different examinations, but we have found our system to be less expensive and just as effective.

These sheets are made the size of the chart and one has on it blank spaces for five analyses of urine, and the various blood examinations. The other has on it spaces for reporting sputum, feces, gastric contents, transulates and exudates and pathological specimens. These are filled out in pen and ink, copies of the various examinations being made and kept on file in the laboratory. They are then sent upstairs to be placed on the patient's chart.

In this particular laboratory, the City Board of Health work is done and we are also a branch laboratory of the State Board of Health.

The laboratory is self supporting in that it costs the Sanitarium little or nothing to maintain, because it is owned privately by physicians who make laboratory work their specialty.

The Hospital Laboratory

Dr Geo. Walter, Monroe, La.

Problems and Obligations.

IN presenting the laboratory problem, and it is a serious one, there are so many definite points of attack that one must select some vital question about which to build up a reasonable discussion.

Time forbids details and at every angle we find objection to overrule and argument to meet. It is with considerable misgiving that I have accepted the opportunity to offer this study of the obligations which the laboratory must recognize and vice-versa, the problems which the hospital inevitably meets in making the fulfillment of the obligations possible. To my mind the principal issues are three-fold:

1st. The establishment of a suitable equipment which includes housing, installation and personnel and is the primary requisite which the hospital faces.

2nd. The obligations which the laboratory must recognize toward hospital, patient and profession.

3rd. Adaptability to practice, which is the basis upon which the institution will build up its support and includes purpose, efficiency and service.

I have chosen the first group as my main theme, touching lightly on the others as means of ascentuation. The great mass of literature on laboratory service touches but lightly if at all upon the hospital problem and we daily hear the lament from all sides—"such an expense—if we could only have our laboratory like such an one, what an opportunity for better work and improved technique would be ours."

In advance let me state the final assurance that while much of this is unavoidable under the prevailing conditions, experience has taught me that within certain well defined limits, the successful, self-supporting laboratory is within the grasp of all hospitals. This may seem somewhat exaggerated. Let us first consider the hospitals in groups. There are:

1st. The large general or specialized hospitals which by their advantages assume positions as centers with unlimited support. These institutions are comparatively few in number and exist only under most favorable conditions.

2nd. That great group of hospitals such as are found in cities like Shreveport where institutional competition is keen and public sentiment distinctly divided.

3rd. The small community hospital sometimes ill-organized and as a rule poorly endowed if at all, or barely self-sustaining.

From the laboratory standpoint we must first consider the professional obligation which the unit as a scientific facility bears toward the patient as well as the attending physician, either general or specialized and what this means to the latter. We recognize the primary requirement is value to the patient. With this as the fundamental fact, the only service rendered is indirect, and summarizing we find that the ultimate theoretical result is:

1. Practical diagnosis aid which leads to

2. Assistance in raising individual professional excellence by

3. Proving or correlating clinical findings, and assistance in correcting mistaken deductions. This last might be considered one of the greatest services of all, and in the end leads to research and investigation.

Let me here mention the post mortem in passing. We all make mistakes, have doubts, create constructive disputes and question obscure diagnoses. The greatest aid in clearing an amazed brain is the autopsy room. Here in a few moments, weeks of suspense and uncertainty may be relieved. But greater than all these and allied considerations, the future case of similar type with its obscure complications may become an open book. Those who make use of the advantages of the autopsy room are the true progressives; there is no doubt of the post mortem findings being the greatest aid in the study of disease. It is with reluctance that I turn from this feature of the laboratory service to the main theme.

The result means safety in practice and will ultimately gain for the hospital and the profession that confidence which patients representing the public should have in their medical attendants, but so often lack through ignorance, aggravated by grave mistakes and consequent prejudice. Permit me to inquire, how is the hospital to be of service to both patient and physician unless its scientific departments accomplish the fulfillment of this ideal in part at least, by discharging its proper duties faithfully as a diagnostic aid?

The majority of institutions recognize the desirability of standardization and we believe in justice to all that this is the ultimate aid; unfortunately the finances govern their reluctant negatives—but to that, later.

The X-ray requirement is expensive and the pathological and bacteriological laboratory requirements are far beyond the conception usually held by institutional

heads. As a result of this, the outcome of most efforts is discouragement, through ill advised means.

Every laboratory must start at the very bottom rung of the ladder, but the ideal should ever be the bait for progress. The great mistake usually made is based upon the fatal initial consideration—personnel—not finance.

The scope of a laboratory and its purpose is centered about its organization. Good tools are necessary to all workmen, but a good workman may accomplish wonders incomparable with limited means and if idealism walks hand in hand with practical effort, the pinnacle of achievement is in sight and success assured.

Consider the first hospital group before mentioned; the institution of unlimited ways and means. Here we find the so called big men; men of brilliant ideals and remarkable achievements; behind them there is the roentgenologist of sectional or national repute, the bacteriologist whose name appears in text books or by which certain organisms are known, the pathologist whose word is final in all questions of moment and whose opinion is quoted by students of today, and because of his progressiveness, will be quoted tomorrow and by the children of tomorrow. About these institutions, the aura of national or sectional fame hovers because the specialists in all branches of medical science practice there and will continue to do so. The nurse students become tomorrow's superintendents or executives in their varied capacities because of the ability of the institution to select its applicants and train them under men of vision and ability. Patients come from great distances and consultations are of daily occurrence. These men are the nucleus of a medical center because they *practice medicine*. It is not the *medical game*, but the science of medicine which they study and promote. These men demand good laboratory facilities and their demands are met.

The second group is much larger, more widely distributed and to this group the laboratory is a real problem, but much more than need be. Means are limited, oftentimes apparently unprocurable. Space is difficult to provide and the personnel must be chosen under disadvantage. What has this institution to offer,— is its staff anxious to practice medicine or "play the game?" Usually the former. Most medical men are more or less visionary, idealistic, many contrary opinions notwithstanding. Thirty years ago laboratories were rare scientific workshops, mostly of value for research purposes—unrecognized in practical life. As the values of these units became recognized the older men studied and read of their achievements and advantages, but were unable to avail themselves of the results of these efforts because these institutions were too far removed from the fields of their endeavor. To be of service the laboratory must not only be in the immediate vicinity, but accessible. The demand has often created the supply, but we regret the supply has too often been inadequate.

The hospital groping in the dark procures a small amount of equipment suitable for routine blood and urine examinations and a technician. The technician may have been well trained or not, according to the fortune of the employers or the character of the advice available. The laboratory may be poorly situated and crowded into limited space. Result—failure, which might well have been turned to success. No technician is a satisfactory interpreter but may be an excellent producer of technical results. What the profession wants in justice to the patient is a *diagnostic aid*. We will not discuss laboratory equipment because time forbids. We merely state that the hospital owes the patient and the doctor a well situated, available interpreter of diagnostic laboratory results and equipment sufficient to inaugurate such service.

The growth of the laboratory under such a system will be assured. The demand will create progressive development of every branch of laboratory service including the most intricate blood and urine chemistry examinations and metabolism.

The establishment of such a service is possible in any community of sufficient size to maintain a 75 bed hospital as a center for caring for the sick. This applies to all hospitals of the second and third classes as mentioned before. It is available of course, in many of these cases to procure combination men so called, who can supervise both X-ray and pathological departments.

The main pre-requisite is to choose the organization head and develop the laboratory according to the principal requirements until special demands adapt the laboratory to increase expenditures required.

As a basis upon which to establish its standing and value to the profession, the laboratory must recognize in justice to the patient, the necessity for certain classes of routine laboratory work which every patient must receive as soon after admission as possible, and at other times as required by the physician or the hospital in the common interests. Such examinations usually consist of complete blood examinations including white total and differential estimate and often red total and hemoglobin by which the patient's resistance is shown, and routine urine examinations covering all common tests and microscopic observations,—cultures of infected wounds and such bateriological examinations as may tend to perfect and check the services of the hospital, this to include cultures in and about the operating room both during operations and at other times as indicated in order to show character of sterilization and proper preparation of the patient and the condition of the air in the operating room at all times. It should be possible that the indigent poor receive any examination necessary for their care and if possible, cure. It is not always convenient or expedient to give all patients any examination required for a flat fee and we must therefore make it possible for all patients to get what they require on a basis which will be satisfactory for the proper conduct of the laboratory in the interests of the patient and the institution. If this is done the attending physician will have every opportunity to give proper attention and no excuse for failure in technique.

A further routine requirement and one which is materially essential, demands that all tissues, fluids, pus in fact any excretions, secretions or excised material of any nature whatsoever, taken from or given off by the patient in the operating room should be sent to the laboratory for disposition or examination. It should be the problem of the pathologist to take charge of all such material and these things should be destroyed or thrown away only by him, thus assuring the institution of proper observation or examination of all such material.

Finally, where will the money come from? This might well have been the title of my paper had I not desired to put it in second place, since that is where I consider it in importance.

There are several methods for making a laboratory self-sustaining, and they are practical. The initial and in fact the most practicable method would be for the institution to charge each patient a rate sufficient to warrant the hospital in giving that patient any and all examinations without further charge no matter what the character of the service. This is not always advisable as circumstances and local conditions dictate modifications. Hospital practice is daily becoming more and more expensive as all other economic requirements increase in cost, in view of the fact that technical requirements are more exacting. Such a basis might easily be established in some communities and it should be possible in all eventually. This should be the ultimate aim of the institutions.

To illustrate: A patient paying seventy dollars a week for a room certainly would be willing to pay eight or ten dollars a week for scientific service which would guarantee him every attention and convenience within the scope of the hospital. On the other hand a poor patient paying fifteen dollars a week could easily pay two dollars a week for the same service. The average on a basis of this kind would be a sum total sufficient to conduct a laboratory in a highly satisfactory manner and pay the salary of a director and technicians thoroughly competent to carry on their various divisions as assigned.

Next in importance I consider a standard charge for all routine work on a graduated scale the ideal method, with special fees for work not included in the list of compulsory examinations. In one hospital with which I have been connected, the routine fee was the daily rate the patient paid for hospital accommodation; a patient occupying a two dollar bed pays two dollars for all routine laboratory work done during the stay at the hospital whether it be one day or one year. A patient occupying a six dollar room likewise pays six dollars for the same service. Thus, the means of the patient dictate the routine fee required as in the aforementioned method. All special fees were standardized according to a fixed schedule. Charity patients and out clinic patients, of course, receive all laboratory service free, except X-ray which is done practically at cost, defrayed by special funds of the institution.

Another hospital charged three dollars flat fee for routine to all patients, with special fees additional for other tests including X-ray. It will be seen that this system is not unsatisfactory from the patient's point of view and through this method the hospital maintains a suitable technical department which I have never seen to fail though no income was obtainable. It is to be remembered, however, that the hospital never considered the laboratory as a source of income and furthermore, that most scientific units are an expense. This is not just. A condition which will enable the unit to be self-sustaining is highly desirable and is still but a dream to many well established institutions in all other respects. From the standpoint of the executives in control there seems to be but one satisfactory solution and that is to make the location attractive. Well trained laboratory executives are difficult to procure due to the fact that until quite recently, the institutions expected trained men to work on a salary at technicians' incomes. To obtain these specially trained medical men the income must at worst compare favorably with that of other specialists of the average type and the better the man the better the income required. No capable man would accept a salary unless it was equal to an income within the limit of his earning capacity. Give him a good workroom and progressive staff members, full hospital co-operation, reasonable pay for doing the routine or proper help in this work and the right to develop the laboratory to the utmost in the combined interest of the institution and himself and the character of his work and service alone will develop the hospital laboratory beyond your fondest dreams providing he is the right man and the hospital recognizes the problem from the viewpoint of the patient and the medical staff.

Post-Operative Pneumonia — Its Treatment in the Congestive Stage

S. W. Boyce, M. D., Shreveport, La.

PNEUMONIA that scourge that has been christened "King of Death," has by modern methods of preventative medicine been dethroned and robbed of a small part of its terror; but, still we see it as a malady before whose ravages we feel deeply our utter helplessness. The signs, symptoms, course, complications and sequelae are very definitely recognized and combated. Specific therapy has aided us too little in its control. I have found no new etiology or specific therapy but by correlating the results in a series of cases coming under my care. I have evolved a procedure which has greatly aided my patients. Such procedure is nothing new, spectacular or original, but has produced results, which I feel, justify consideration.

As an intern, and under the direction of the hospital staff, I began the treatment of pneumonia in its congestive stage by the application of dry heat to the chest wall. The procedure was to cover the patient well with blankets and apply hot, metal plates to the chest constantly for one and one-half to three hours. This produced a profuse perspiration and especially from the chest wall. This heat might be applied by electric pad or hot water bottle, but they have appeared not quite so efficient. At first the heat was applied in various ways, and mustard plaster and sundry other procedures were instituted. Later, I adopted the use of the dry heat alone, applied with metal plates and so far have had excellent results.

Most of the cases I have treated of pneumonia have been Ether Pneumonia or Post-operative Pneumonia. Ether Pneumonia is one of two conditions—It is a septic or nonseptic embolic pneumonia, or it is a congestion both active and passive with oedema of the lung caused by a vosotomor relaxation following anesthesia.

I am unable to say that it is not embolic from the operative field. Our work is practical only, and we can solve no question requiring research work. We can only base our opinion on therapeutic results. Because we have seen so many cases of Ether Pneumonia respond to heat only and in such short time, I have concluded that it is a vasomotor congestive condition rather than an embolic pneumonia. I have no conception of an embolic pneumonia responding to heat applied to the chest for two to four hours and going rapidly to a complete cessation of symptoms. Then from this therapeutic test this condition is an active and passive congestion with oedema.

Then through the energy of the reflex vasomotor mechanism this condition is removed. The patient is bled from his lungs into his overlying chest wall. Based upon physiological known facts, this is all that could occur by the above method. Then, to me, we have here sufficient proof of the etiology and pathology of Ether Pneumonia. We have no more safe and sure method of finding the pathology. The patient does not die at this stage, and of course, later, the course and pathology are no different than the ordinary infective pneumonia.

Case Records.

No. 1. W. D., male, white, age 40, Chr. Appendicitis—operated 9 a. m. Rather restless that night. Saw him at 8 p. m. following night and remarked to nurse "I regret to see that man not doing well." perspiring profusely, restless, couldn't sleep, anxious expression. Called at 3 a. m. Ether Pneumonia. Mustard plaster and hot bottles, pulse 110, resp. 34, temp. 101 1-5. Scared badly. Had had two hypos of Morphine Sulph. Asleep in one and one-half hours. Normal at 1:00 p. m. following day.

No. 2. Colored girl, age six, operation: Tracheotomy for foreign body at 1:00 p. m. Following day at 2:00 p. m. pulse 120, respiration 42, temperature 102, restless. Heat applied two hours and patient fell asleep. Heat applied again for two hours beginning at 5:00 p. m. Next day, temp., pulse and resp. normal.

No. 3. Colored woman, age 30, operation: "Pus tubes." On third day pulse went 120, temp. 102 1-5, resp. 40, very restless. Heat used and patient normal in every way in twelve hours.

No. 4. White girl, age 17, operation: Acute appendicitis at 9:00 a. m. Following day at 6 p. m. patient showed usual signs of Ether Pulmonary Congestion with rise of pulse rate and temp. Heat used with usual results.

You will note that in the above cases, treatment was begun within the first three hours of the disease. Now, I wish to include a series of three cases, which through ignorance, oversight or neglect were allowed to run twelve hours or more with Ether Pneumonia without treatment except a maximal number of morphine injections.

No. 1. L. M., male, white, age 19, operation: Acute appendix at 7 p. m. At 7 a. m. normal and resting, pulse 76, temp. 99.5, resp. 24. At 1:00 p. m. pulse 94, temp. 101, resp. 30. At 8:00 p. m. pulse 114, temp. 103, resp. 40. Heat applied. Sleeping in one and one half hours. Twelve hours later, pulse 94, temp. 101, resp. 34, comfortable. Symptoms gradually subsided to normal in 72 hours.

No. 2. J. A. J., male, white, age 30, Acute Appendix, operation at 9:00 a. m. At 6:00 p. m. normal and resting. Twelve midnight, pulse 100, temp. 101, resp. 30, restless. At 7:00 a. m. about the same, no sleep during night. Heat applied, patient fell asleep and remained comfortable. Normal in 72 hours.

No. 3. Male, white, age 30, operation for appendicitis at 4:00 p. m. Following day at noon, normal. At 3 p. m. pulse 92, temp. 101, resp. 26. 6 p. m. pulse 100, temp. 101.5, resp. 28. 3 a.m. pulse 116, temp. 102, resp. 40. Very restless, had several hypos., begged for doctor called with report that he was dying. Asleep in two hours and still asleep at 8:00 a. m. Normal in about three days.

Being normally something of a theorizing theorist I began to look for a case of the infective pneumonia in which to try this remedy. I report two cases.

No. 1. E. Z., white, age 17, caught cold while in hospital. Felt badly all day. At 6:00 p. m. pulse 110, temp. 102.2-5, resp. 36. Congestion of both lungs giving tubular breath sounds and other characteristic physical signs. Heat applied at 7:00 p. m. for two hours. No symptoms left next morning or since.

No. 2. Male, white, age 35, apparently in good health. Pulmonary hemorrhage at 6:00 p. m. I was called and told patient that condition was likely T. B. Next morning pulse 110, temp. 104, resp. 35. With physical signs of pulmonary congestion especially in the right upper lobe from which the bleeding had come. Heat applied. Next morning patient normal and comfortable. Sputum loaded with T. B. No fever for two weeks.

Recently I read of a case of infective pneumonia in which an artificial crisis was produced by using heat in this way. Following this the patient was comfortable, but as the disease was already well established the signs and symptoms of pneumonia returned. Again a crisis was produced as above. Soon one of these crises became a true crisis and the duration of the attack was very greatly shortened.

Thus, we are able to produce to a far better degree with heat by the diaphasesis and reflex vasomotor drainage what we once tried by venesection, cupping and leeches.

The idea herein expressed is neither entirely new or original. It is only a summary of what we all know, but, perhaps, occasionally inconsistently use.

As to the Contra-indications to this simple procedure I see none. Some books warn against it in organic heart and kidney trouble; but, we use it in Shock and Uraemia with striking results.

The Dietitian and the Hospital

F. H. Walke, M. D., Shreveport, La.

UNTIL very recent years, all that was thought necessary to make a hospital a complete institution, was for it to contain a well fitted operating room and an elaborate assortment of surgical instruments and appliances. As medicine progressed, the X-ray was added to this equipment and the hospital grew famous over night, for with this wonderful penetrating light, all the hidden secrets of nature could be and would be exposed and valuable information given to both the internist and the surgeon. Then came the laboratory with its many physiological and pathological discoveries, and today has taken even more prominence than the operating room, for after all, the diagnosis is the only difficult feature of disease, and with a correct diagnosis made "all things are added unto it." And now with the triumphant procession of modern medicine, rest, diet, and watchful waiting have become the sheet anchor in the treatment and management of all cases of whatsoever character. So we have today, the surgeon, the internist, the specialist, the radiologist, the pathologist, and last but not least the dietitian, all working in perfect harmony each having their intricate and individual duty to perform for the welfare and well being of the patient.

A dietitian is one capable of properly adjusting food to the requirements of the individual in health and in disease; one who is thoroughly trained and familiar with the combinations of the proximate, elementary or food principles of protein, carbo-hydrates, hydrocarbons, salts and water. These persons are educated for this particular work by both by study and experience as are others who select the profession of caring for the sick as their life's calling.

The duties of the dietitian in the modern hospital are numerous. They select, provide, prepare, and supervise the serving of food to the patients, doctors, nurses, servants and all others connected with the institution. Each have their particular needs according to their ailment or position, and food is supplied in keeping with these needs. Of course we realize that the sick are to be more concerned than others in the hospital; there is a special diet arranged and supplied to the medical cases, while perhaps the surgical cases are served a different diet, and again, there are special cases which require combinations of foods given for the purpose of restoring diseased organs for the well being of the entire organism.

In the larger hospitals throughout the country, there are employed metabolic dietitians or to use a strictly modern term "food engineers" whose duty it is to supervise the diets of those suffering from the so-called systemic conditions or diseases caused by disturbances or disorders of metabolism. These dietitians are thoroughly familiar with food chemistry and its ultimate digestion and absorption in relation to the needs of the individual case studied computing accurately to the fraction, the amount of food eaten, its assimilation, the calories obtained, the amount of energy exerted and the residue excreted. The degree of accuracy obtained by these dietitians is remarkable for by diet alone the most pronounced cases yield promptly, when all medicinal remedies fail completely.

The cases which are most benefitted and cured by diet are as follows: Diabetes, the various Nephritides, Thyroid, Cardiac and Skin cases, Obesity, Tuberculosis, Gastro-Intestinal conditions, Rickets, Typhoid, Pellagra and Scurvey; besides enumerable diseases along with the aid of either surgical or medical treatment.

In all the modern hospitals, there is a general kitchen where the food is prepared for the entire hospital family; this includes the doctors, nurses, help and patients. Again there are separate smaller kitchens, termed "diet kitchens" where special foods are prepared for selected cases; both the general and diet kitchens should be under the direct supervision of the hospital dietitian. The duty of the dietitian in the general kitchen is to prepare suitable menus for the various classes in the hospital. It is customary for the resident doctors to have a special dining room and service for them, while the nurses have their own table, and the clerical help have another, and the porters, orderlies, and servants have still another place to eat; and suitable, delectable, substantial and sufficient food, having the proper calories is demanded for their individual needs according to the work required of them. For instance those doing the constant heavy work of the institution need a more substantial, coarse, and at the same time a less expensive diet than do the clerks, office force or stenographers. In the smaller diet kitchens, food is prepared for the very

sick. There is usually a trustworthy senior nurse in charge of these, and this nurse is under direct supervision of the dietitian. The physician in charge of the case consults with the dietitian as to the most suitable diet for his case, and the dietitian in turn instructs the diet kitchen nurse in just what articles of food are to be allowed and served.

The dietitian of modern days is usually a woman, because a woman is by natural selection more drastic than men and is more capable of handling the so-called household affairs. Women, as a rule, are thrifty, ingenious, capable, and steadier than men, and are more willing to devote their whole time to this work. Her work is strictly to assist the physician, and not be considered a hired-hand or an expert cook. It is not possible for the busy doctor to look after every detail in the case, and besides this division of labor allows him to study more minutely the pathological features, and at the same time gives the patient the benefit of modern scientific dietary methods. The dietitians are trained as are other students of medicine. They are taught the physiology and chemistry of digestion, food chemistry, and the various functional and laboratory tests. They should have practical experience in hospitals as do the young graduates of medicine, serve an internship, so to speak, paying strict attention to dietetics and laboratory work. They should be tried out the same as doctors and nurses, given a probation period to ascertain whether they will make good or not. While in this course of practical training they should receive all the consideration possible, encouraged, treated kindly, courteously, and firmly. If they succeed in this course, they should be graduated and given a diploma; if their aptness is lacking, they should be dropped as a "busted medical freshman" and advised to pursue some other line of endeavor.

It may be said however, that there are few hospitals in this country which offer the proper training courses to dietitians and only two or three exist where post graduate instruction can be obtained. The usual course of training extended to the average dietitian consists of being associated with one or a group of physicians, usually a gastro-enterologist or an internist who has a wide reputation for the successful treatment of stomach, cardiac, and renal cases; and about the only qualifications and recommendations the dietitian has is that she worked for Dr. "Blank" of Chicago, or Dr. "Blanketyblank" of New York and therefore this dietitian must be a remarkable one to have been trained under men with such a wonderful reputation. I ask the question then, is it fair to the specialty of dietetics to place a person, trained in this manner, at the head of the school of dietary in a hospital and expect results? No, I say, that results cannot be obtained until the dietitian is appreciated as a valuable adjunct to the medical profession as is the radiologist and pathologist.

In conclusion let me say that the hospital is not the only institution which has use for a dietitian. Some of the leading hotels, restaurants, schools, industrial plants, dining car syndicates and even the U. S. Army and Navy have found the need of these "Food Engineers." It has been long since discovered that modern diet is not a fad fancy or whim, but practical experiments have conclusively proven that the so-called balanced ration can and will produce more work, more energy, better health, and much more happiness than just ordinary diets; therefore the economic value of the dietitian is four fold. And since our sick not only need but demand the proper and choicest dishes of the culinary art, in the light of our present knowledge, we are led to believe that the dietitian is a fundamental necessity of every hospital.

The Necessity of a Dietitian

Sister Mary Victory, Amarillo, Texas

ALTHOUGH hospital life is one of the oldest forms of group living, the problems to be solved in successful administration of any department are more varied than will be found in any group. The question of food service is a very important one and in every hospital there should be definite organization of the food department whether we view it from the standpoint of economy, efficiency or service. A study of the food departments of typical hospitals indicate that as yet institutions have developed no plan of a standardized organization.

2. Among the many solutions offered the most practicable and self evident one seems to be the Dietitian. There should be one head of the food department, as well as one head of the hospital as a whole. The one best suited for this position is a competent, well trained dietitian, who should be responsible to the hospital superintendent and should have authority in dietetic matters over the entire hospital. While she serves as administrator and as teacher of others, yet she should have assistants and a defined plan or policy, otherwise her duties will become far too varied and numerous, and thus become detrimental to the whole department.

Function of the Diet Kitchen Laboratory.

1. The number of assistant dietitians and the number of pupil nurses who are taking their dietary training should depend upon the size of the hospital. The term of the pupil nurse should be two months each; one spent under the assistant and one under the head dietitian.

2. In the diet laboratory the duties of the head dietitian should be a personal planning and a supervision of the daily menu, preparation of food for *metabolic* cases, the weighing and calculating of food values; the filling of special diet prescriptions, and the preparation of food for infant feeding. The senior nurse should be under her instruction in these diets that she may thus acquire a thorough training.

3. The assistant dietitian and intermediate nurse should see to the preparation of salads, special orders, light desserts and "between" nourishments. All requisitions should be received before 9:30 a. m. It will be great economy both as to time and material to have all "between" nourishments prepared in the diet laboratory and distributed from here to hall nurses. Time of nurses should be arranged as to have one constantly on duty in order that any new requisition may be attended to.

4. The cooking course for the pupil nurse who is under instruction should be planned with a view that these prepared foods can be used in serving patients. When all work is completed it should be distributed to the various kitchens, at appointed meal hours.

Function of Floor Serving Room.

1. The function of the floor serving room is to prepare toast, small steaks, tea, cocoa, set trays and provide for the dish washing. While these diet kitchens are directed by the dietitian yet a Sister especially trained for this purpose should be in immediate charge. She should have a good reliable maid to attend to routine work such as tray setting, toast making and dish washing. The Sisters in turn can act as assistant dietitian which will be to them a training for the more responsible charge of dietitian, provided that they have a thorough theoretical course. Special attention should be given to tray service. Attractiveness in the patient's tray is a primary requisite. It is a great factor in psychic digestion, for through sight the sense of taste is stimulated; and the appetite once tempted is led on to real desire for food which in turn stimulates the gastric digestion.

The Keynote to Attractiveness in Tray Service is Absolute Cleanliness.

At the appointed meal hour each Sister in charge will be responsible for this cleanliness and attractiveness. She should do the actual serving with the help of the diet student nurses. The senior student should as far as possible attend to the serving of metabolic cases, and prescription diet filling, as she should be held responsible for

the checking up of unutilized food in order to make proper calculation.

During the meal hour the dietitian and if need be, her assistant should "follow up" as it were the food. Note the waste and what is not eaten and find out why the patient did not partake of what was served. By this personal contact the patient is pleased; he appreciates this personal interest and immediately responds by co-operating in many little helpful ways, for he realizes that the hospital is striving to give him service.

When the dietitian finds the patient is not eating and she knows the reason is not due to any fault on the part of the food department, she must report to physician and consult with him as to what nutritional method he wants. The dietitian and head nurse must come in close contact and frequently consult about the patient's nutritive needs and results developing therefrom. The individual must be studied.

Administrative Duties.

In regard to the dietitian's administrative duties one must be guided by the size of the hospital. She should, as said before, have full control of the food department, but with necessary assistants that she need not take time to attend to minor details; as to the ordering of supplies, it will save much time if this be done by some one else provided she can be consulted, and her requisitions, on approval of superintendent be heeded.

Advantages of Having a Dietitian.

Briefly summarizing; the necessity of a head dietitian is evident from the benefits that accrue to the hospital in general, to the patient, to the doctor and the student nurses; a competent dietitian will go far toward establishing economy, efficiency, and satisfaction. Efficiency is measured, in the last analysis, by the service rendered to the patient. The patient becomes contented because the hospital is doing its part to supply his needs and help relieve him of his ills, through scientific feeding. Then too the patient learns his dietary needs to insure health. The dietitian can be a great aid to the physician. She sees that his orders are properly carried out and thus gives him the satisfaction of working more scientifically. Finally the student nurse is also benefited for on leaving her school she will be able to feed her patient scientifically to his good, and satisfaction of attending physician.

(Proceedings of Southern Conference will be concluded in an early issue)

MINNESOTA CATHOLIC HOSPITALS ORGANIZE STATE CONFERENCE.

Thirty Sisters conducting hospitals in Minnesota met at St. Mary's Hospital, Minneapolis, Minn., Tuesday, May 23, to form a State Conference under the direction of Rev. P. J. Mahan, S.J., Vice-President of the Catholic Hospital Association. Father Mahan explained the object of the organization, the advantages to be derived from it and what has been accomplished by state conferences in other States. The constitution and by-laws were adopted and officers elected as follows:

President, Mother Madeleine, St. Mary's Hospital, Minneapolis; first Vice-President, Sister Domatilla, St. Mary's Hospital, Rochester; second Vice-President, Sister Olivia, St. Mary's Hospital, Duluth; third Vice-President, Sister Serena, St. Raphael's Hospital, St. Cloud; Secretary-Treasurer, Sister Elzear, St. Mary's Hospital, Rochester.

Executive Board: Sister Philomem, St. Gabriel's Hospital, Little Falls; Mother Eustacia, St. Vincent's Hospital, Crookston; Sister Adolphine, Loretta Hospital, New Ulm; Sister Agnesina, St. Joseph's Hospital, Mankato.

The Executive Board will meet soon to arrange for the official meeting to be held early in the fall.

CHICAGO ROUND-TABLE CONFERENCE

The superintendents of the Catholic Hospitals in Chicago have recently formed a round-table conference. The first meeting of the conference, which was held April 13th, was divided into five groups comprising the following departments of hospital work:

Group One.—Superintendents of hospitals, superintendents of training schools, and pharmacists.

Group Two.—Supervisors of floors, supervisors of obstetric and pediatric departments, instructresses of nursing and hospital buyers.

Group Three.—Supervisors of operating rooms, anaesthetists, and supervisors of surgical supplies.

Group Four.—Sisters in charge of registration and information, and record-keepers.

Group Five.—Sister supervisors of social service, supervisors of dispensaries, x-ray departments and dispensaries.

It is planned to continue the form of organization and procedure throughout the year.

A total of five hospitals, comprising Mercy, St. Bernard's, St. Mary of Nazareth's, St. Joseph's and St. Anne's are cooperating in the work of the conference.

OHIO CONFERENCE OF HOSPITALS.

The Ohio state conference of hospitals was held May 8th at the Miami Hotel, Dayton, O. Rev. Charles Hickey, Pastor of Sacred Heart Church, Dayton, O., gave the address of welcome, while Rev. F. A. Gressle, Director of the Catholic Charities League, Cincinnati, made the introductory address. Rev. C. B. Moulinier, President of the Catholic Hospital Association, also made a talk. Sister Mary Gervase, Mercy Hospital, Hamilton, talked on "The Sister in the Modern Hospital"; Sister Mary Perron, St. Vincent's Hospital, Toledo, discussed "Administrative and Educational Problems of the Catholic Nursing Schools," and Sister Rose Alexis of Good Samaritan Hospital, Cincinnati, had charge of the round table of Sisters in the respective hospitals.

The second annual conference of diocesan hospital superintendents was held May 22nd, at Buffalo, N. Y.

A special meeting of the officers and chairmen of the standing committees of the Wisconsin State Conference was held March 2nd, at St. Joseph's Hospital, Milwaukee, Wis., with Sister Mary Rita presiding.

The conference decided to hold the next meeting on August 22nd, at St. Mary's Academy, St. Francis, Wis. A program committee consisting of the President and three members was appointed as follows: Sister M. Rita, Sister Theodora, Sister M. Praxedes and Sister St. Patricia.

A committee of three, consisting of Sister Bernard, Sister Alberta and Sister Praxedes was appointed to make a study of the Uniformity of Records. The committee has been asked to create sentiment favorable to uniformity of case records in Wisconsin.

OFFICERS ELECTED.

The Conference of California, Nevada and Arizona Hospitals has elected the following officers and committee members for the following year. The officers and committees are as follows:

Honorary president, Archbishop Hanna, San Francisco, Calif.; President, Sister Zoe, St. Mary's Help Hospital, San Francisco; First Vice-President, Sister Eulalia, St. Joseph's Hospital, Stockton, Calif.; Second Vice-President, Sister Angela, Providence Hospital, Oakland, Calif.; Third Vice-President, Sister M. Joseph, St. Joseph's Hospital, Eureka, Calif.; Treasurer, Sister Rosina, St. Francis Hospital, Santa Barbara, Calif.; Secretary, Sister Evangelista, St. Mary's Hospital, Tucson, Ariz.

Executive Committee: Rev. Father R. E. Lucey, Los Angeles, Calif.; Rev. Father M. Power, San Francisco, Calif.; Dr. Edward Dillon, Los Angeles, Calif.; Dr. T. E. Bailey, San Francisco, Calif.; Thos A. Farrell, Sacramento, Calif.

Committee on Information: Sister M. Malachi, St. Mary's Hospital, San Francisco, Calif.; Sister Dolores, St. Mary's Help Hospital, San Francisco; Mother Bernard, St. Joseph's Hospital, Eureka, Calif.

Legislative Committee: Mr. Thos. A. Farrell, Sacramento, Calif.; Sister M. Carmel, Miseriocordia Hospital, Sacramento; Sister Sylvia, St. Joseph's Hospital, San Francisco; Sister M. Gabriel, St. John's Hospital, Oxnard, Calif.; Sister Helen, St. Vincent's Hospital, Los Angeles.

GRADUATES OF ALL SOULS' HOSPITAL, MORRISTOWN, N. J. CLASS OF 1922.

Committee on Cooperation: Rev. Father M. Power, San Francisco, Calif.; Rev. Father R. E. Lucey, Los Angeles; Rev. Mother Bernard, St. Mary's Hospital, San Francisco; Mother Mary Vincentia, St. Mary's Hospital, Tucson, Ariz.; Sister Fidelis, St. Elizabeth's Infant Home, San Francisco.

Committee on Constitution and Bylaws: Sister M. Angela, St. Joseph's Hospital, San Diego, Calif.; Sister Eulalia, St. Joseph's Hospital, Stockton, Calif.; Sister M. Matilda, Providence Hospital, Oakland.

Class of 1922 Graduated. The class of 1922 of Mercy Hospital Training School, Charlotte, N. C., held their graduating exercises on Friday evening, May 19th, at O'Donohue Hall. Dr. Myers Hunter, president of the hospital staff, presented Mr. C. H. Gover, who made the principal address of the evening. Rev. Father Felix addressed the graduates and presented the diplomas. A reception and dance followed the exercises.

Begin Work on Nurses' Home. Construction work on the new nurses' home for Mercy Hospital, Charlotte, N. C., was begun on June first. The building, which will be of fireproof construction throughout, will cost about $50,000.

Commencement Exercises. The annual commencement exercises for Mercy Hospital Training School, Baltimore, Md., were held on May 9th, with Most Rev. M. J. Curley presiding. Dr. John J. Erwin acted as master of ceremonies and Most Rev. M. J. Curley presented the diplomas. Rev. Joseph Mallon gave the address to the graduating class. A class of thirty nurses was graduated.

Hospital Addition. An addition will be erected at St. Agnes Hospital, Fond du Lac, Wis., at a cost of $500,000. The plans provide for two complete units, one to be devoted to administration and operating departments and the other to patients.

GRADUATE NURSES, ST. JOSEPH'S HOSPITAL, JOPLIN, MO.

Hospital Progress

Editorial Board

EXECUTIVE COMMITTEE:
C. B. Moulinier, Milwaukee, Wis., Chairman.
B. F. McGrath, M. D., Milwaukee, Wis., Secretary.
Edward Evans, M. D., La Crosse, Wis.
Frederick A. Stratton, M. D., Milwaukee, Wis.
Edward L. Tuohy, M. D., Duluth, Minn.
William C. Bruce, Milwaukee, Wis.

ADVISORY AND CONTRIBUTING EDITORS:
Sister M. Camilla, St. Joseph's Hospital, Chicago, Ill.
Sister M. Cherubin, Mt. St. Mary's Hospital, Niagara Falls, N. Y.
Sister M. Concordia, St. Mary's Infirmary, St. Louis, Mo.
Sister M. De Pazzi, Mercy Hospital, Chicago, Ill.
Sister M. Genevieve, St. Elizabeth's Hospital, Youngstown, Ohio.
Sister M. Innocent, Mercy Hospital, Pittsburgh, Pa.
Sister M. Joseph, St. Mary's Hospital, Rochester, Minn.
Sister M. Madeleine, St. Mary's Hospital, Minneapolis, Minn.
Sister M. Magdalene, St. John's Hospital, Springfield, Ill.
Sister M. Marie, Huber Memorial Hospital, Pana, Ill.
Irvin Abell, M. D., Louisville, Ky.
J. Alexandre Saint-Pierre, M. D., Montreal, P. Q., Can.
John T. Bottomly, M. D., Boston, Mass.
Rev. Michael P. Bourke, Ann Arbor, Mich.
Joseph Byrne, M. D., New York, N. Y.
Edward T. Dillon, M. D., Los Angeles, Calif.
Michael F. Fallon, M. D., Worcester, Mass.
Rev. Peter P. Finney, C. M., Dallas, Tex.
Rev. Edward F. Garesche, St. Louis, Mo.
Rev. Maurice F. Griffin, Youngstown, Ohio.
William C. MacCarty, M. D., Rochester, Minn.
Hugh McKenna, M. D., Chicago, Ill.
Rev. P. J. Mahan, Chicago, Ill.
Charles L. Mix, M. D., Chicago, Ill.
Edward L. Moorhead, M. D., Chicago, Ill.
Austin O'Malley, M. D., Philadelphia, Pa.
Eugene Saint-Jacques, M. D., Montreal, P. Q., Can.
Rt. Rev. Joseph Schrembs, Toledo, Ohio.
Horatio B. Sweetser, M. D., Minneapolis, Minn.
James J. Walsh, M. D., New York, N. Y.
Frank S. Wiley, M. D., Fond du Lac, Wis.

FASHION DEGRADING THE NURSING PROFESSION.

Page 208 of the May issue of Hospital Progress contains an article by a Sister of Providence, enunciating some most inspiring principles. A recent Paris dispatch related that some bold Parisian beaux ventured forth gaily festooned and attired in evening clothes made of highly colored fabric. Dame Fashion frowned audibly, not because of any particular fear that those who *work* might appear effeminate, but because those who *weep* needed the conventional black attire of their escorts to furnish the proper background for their copies of the "birds of the air and the lilies of the field."

Fashion has dictated to many a shop girl that furs are a necessity and food an afterthought. She has subsisted on half rations, and mortgaged her body, if not her soul, to instalment houses.

Nurses should dress as well as they can afford; the public is quick to note lapses from good taste.

It would certainly be in poor taste for any mere man to enter into any detailed discussion as to what a nurse should or should not wear, but a few crisp statements as to the abuse of perfume (fortunately stressed in the Sister's article) cannot be amiss:

Historians have had much to say about the accidental discovery of America, while the real purpose was a quest on the part of Europe for a nearer route to the spices and perfumes of the Orient. They have not had enough to say about why they wanted these same spices and perfumes. Here is the chief answer: Cold storage was unknown in those days; garbage collection and sewer systems were as unknown as radio concerts; running water was confined to babbling brooks, and bathing had not become an obsession; therefore, fresh food soon became foul, and the olfactory sense had to be overpowered by spicy additions in cooking. Johnny the odoriferous, whose mother told the teacher, "He aint no violet," would not have been singled out for persecution in that day; if he could have afforded it, he would have been abluted with ten cents' worth of five-cent perfume.

Now, girls, if in the face of this you are not convinced, keep on using it—I have done my best to reform you. No finer aroma has been discovered than that resulting from the use of pure soap.

E. L. T.

BIG THINGS.

In the conduct of a hospital, there are big things as well as little things. The biggest thing in a hospital is an intelligent appreciation of what a hospital really is. This means that the hospital management must realize that their work is a specialty. Everything nowadays is specialized, nothing perhaps more than salesmanship. The hospital has something big to sell; the management must realize this. What they have to sell is health, preserved or restored. Now the one big function of a hospital is to restore health, though to the casual onlooker this may seem their true and perhaps only function. But because of the specialized knowledge which they have, or should have, they should be a community center, ever giving out information directly or indirectly. Not only through the instructions given their patients while in the hospital, but also by an advanced educational health campaign in their community, must they be a great factor in the community's well being—here enters the social worker.

As we do not live by bread alone, so the hospital must not merely be a well equipped, scientific institution, but it must also have a proper aesthetic sense. The surroundings of the hospital should be beautiful and inviting and tastily landscaped. The more exclusive grounds for the use of the patients should have pleasant, comfortable resting places, with shrubbery and flowers.

After all, the biggest thing for a hospital is its personnel. The time is past when any well conducted hospital can hope to fulfill its mission to the fullest without a trained hospital superintendent. One who has so absorbed the better things, one who understands and demonstrates in her own life the highest qualities that make the BIG trained nurse, together with a deep understanding of the duties and possibilities of the educated hospital superintendent, is needed.

With such a head, any hospital almost must be a success, for he or she, will so educate and enthuse those under supervision that there will be a competent, harmonious coordinated machine that must make for efficiency. Some hospitals are overorganized from the scientific standpoint and the great spiritual human force that makes patients happy and conduces to their recovery, is absent. This, I think, is, however, seldom seen in the Sisters' Hospitals.

The under-graduate teaching diet kitchen is now a necessity. It must be in all our hospitals pretending to be standardized. It must be so kept that the dietician in charge— and of course no good Sisters' hospital now is without a trained dietician—can give the instructions necessary to make nurses in training efficient in the culinary art as applied to the sick.

The management that has backbone to see that their staff is not merely organized,—a word overemphasized just now—but that the staff is both honest and efficient in the work that each individual member of it attempts to do, is a big need today in our hospitals.

If we would only in the conduct of our hospitals attempt to visualize every case in such a way that we could frankly ask ourselves "Is this the way that I would want my father or my brother to be taken care of?" or "Is this particular doctor the best qualified on our staff to treat this particular case?" we would have better work, uniformly done.

To approach to such a state of perfection calls for tact as well as backbone because when a member of the staff sends in a patient the management can't take it away from him, however they may feel about it. But if our staff organization means anything, it means that a patient is entitled to consultation when it seems necessary and a properly organized staff should at all times be willing to render frank and honest assistance to any other member of the staff who may ask for it. And any member of the staff who constantly avoids having consultation should at least be under surveillance.

Only by thinking about the little things and the big things in our hospitals today and speculating on what are to be the big things, as well as the little things, in the future can we hope to be big ourselves and be a big factor in the welfare and well being of the community we are serving.

E. E.

LET US HELP ONE ANOTHER.

In every effort to make things better in this world many difficulties are encountered. If the effort develops into a campaign or propaganda; if standards are set up and rules and regulations put down to be followed; if ideals are aimed at; and above all, if different kinds of people, especially different professions, are involved in the campaign for betterment, there is always one great obstacle to real progress and that is the human tendency to blame others for all that goes wrong.

What is this "spirit of blame"? What is its psychology? What is its genealogy? What are its characteristics? To blame another, is to find fault, to accuse, to reprimand. This tendency to throw the blame on others seems to be a human inheritance coming to us all from the Garden of Eden. It usually involves an *excuse for self*. It often means a lack of duty performed on the part of the accuser. It almost invariably presupposes selfishness and conceit. This is quite true between individuals and is very likely to be true when classes of individuals are concerned.

The new hospital is a unified, complex institution whose unity comes from its purpose—service to the sick, and whose complexity grows out of the fact that three professions are necessary to make this service effective and up-to-date—the medical profession, the nursing profession and the hospital profession. Under the exacting stress for a better service to the sick there is a very noticeable inclination on the part of doctors to blame the management, the Sisters, or the nursing force if anything goes wrong with the patient, while in turn the nurses show a tendency to blame the doctor or the superintendent, and the superintendent quite naturally seems to think it her first line of defense to blame the doctor or the nurse. This is all very human and very natural and, therefore, must be expected from time to time, but it is all very weak and selfish and unprofessional and quite sure to hinder real progress in service to the sick. If on the other hand the medical staff in a hospital would always be most eager to blame itself for its own shortcomings; would do its work more industriously and self sacrificingly; would be more eager to know and appreciate the help given for the care of the sick by the nurses and the hospital authorities; would deeply realize that without such assistance by day and by night their patients could not be cared for; if, in brief, the members of a hospital staff could realize their full indebtedness to the hospital, the organized institution, and be more ready, therefore, to praise than to blame, all the patients would benefit by a greater spirit of helpfulness and cheer within the hospital. The same must be said with less emphasis, however, perhaps, about the nurses and the hospital authorities. Let us help one another, but let the doctors set the pace for this spirit of helpfulness by deeper, broader, more manly and more professional appreciation of all that is done for them within the hospital. Wherever this spirit is distinctive of a hospital all is peace and joy in a splendid spirit of team work, to the honor and credit of all and for the lasting benefit of the patient.

C. B. M.

AVOID MISUNDERSTANDING.

Constant experience in a work points out places wherein misunderstandings are apt to arise. Things look much different when viewed from a distance, and not uncommonly truth suffers because of this fact. Therefore it might be well, now and then, to make an endeavor to clarify conditions about which there may exist some doubt.

A point which presents itself at this time is one concerning the editorial space of HOSPITAL PRO-

GRESS. Up to now this space has averaged about forty-two pages, and there does not appear to be a good reason for increasing it for some time to come. Editorial material so limited that it will be read and digested by a majority of the readers manifestly attains nearer to the purpose of a publication than where the amount is so extensive that it is either, for the greater part, unread or, at the most, superficially perused. In the light of this, should we not aim at quality instead of quantity? Should we not constantly keep before our minds education, and information that will serve a useful purpose?

Apropos of this is news frequently submitted for publication. Of course, all news of the Association's hospitals is wanted and very welcome, but sometimes it is not practicable or beneficial to publish it. In the one case, the news may arrive just too late for insertion in the coming issue of the magazine, and may not be "news" when the following issue will have appeared.

It may be well to state here that the printer's forms for HOSPITAL PROGRESS close on the tenth of each month; but, in justice to the work of the publishers, if possible, the material should be in on or before the first of the month.

In another case, there is so much news of the same nature coming in at once that it must be cut down, in order to do justice to all, and so as not to crowd out the main editorial material of the magazine. As examples of this point are the reports of "Hospital Day" and graduating exercises. Many of these are most interesting and excellently presented, but must be reduced, even though often with much reluctance.

However, we urgently request all continually to send in news, as well as other material, and hope that you will trust us to do whatever we can to please, always bearing in mind that real service has the first place. *B. F. McG.*

HOSPITAL NEWS.

Minimum Standard for Hospitals. At a meeting of the advisory board of St. Mary's Hospital, Grand Rapids, Mich., held on April 20th, Dr. W. H. Veenboer, Chief of the Medical Staff, talked on "The Minimum Standard as Applied to St. Mary's Hospital." The five definite requirements for a standard hospital as outlined by the American College of Surgeons have been accepted and incorporated in the hospital for the past two years. St. Mary's Hospital accommodates approximately one hundred patients. During the past year 3,509 patients passed through the hospital and the average number of patients present every day was 83. The average cost of each patient per day was $4.50.

St. Mary's Hospital recently received splendid publicity in the Catholic Vigil, the official paper of the Grand Rapids Diocese. The two leading articles on the first page of the issue for May 10 were devoted to "Hospital Day" observation at St. Mary's and to the address of Dr. Veenboer.

Hold Bazaar. On April 20, 21 and 22 the Sisters of St. Joseph, at Lewiston, Ida., held a bazaar to raise funds for a new wing at the hospital. About two thousand dollars were realized from the bazaar.

Annual Retreat. The annual retreat for the nurses of Mercy Hospital, Cedar Rapids, Ia., was held May 14 to 18 at the hospital. The alumnae members as well as the student nurses were in attendance.

St. Francis Retreat. The St. Francis Hospital Training School at Pittsburgh, Pa., was recently visited by Rev. Father Matthias, of West Hoboken, N. J., who conducted a four-day retreat for the graduate and student nurses, numbering 150.

The St. Francis nurses are looking forward with pleasure to the early completion of the new dining hall. It is one of the most complete in the city and is a much needed addition to the school.

The nurses of St. Francis Hospital, Pittsburgh, Pa., held a bazaar April 27-29, which proved a success. The sum of $2,700 was raised which was presented to the hospital to help defray the cost of the new dining hall.

In Memoriam. Hotel Dieu Hospital, Chatham, N. B., sustained a heavy loss on May 3rd, in the death of two valued friends of the institution, Dr. P. F. Duffy and Mr. James F. Connors. Dr. Duffy was president of the medical staff of the hospital and took great interest in all that pertained to the success of the institution. Mr. Connors was the legal advisor for the hospital for more than 25 years.

Both gentlemen through their unselfish service, earned the gratitude of the Sisters of the hospital, which debt the latter strive to repay by earnest prayer for the repose of the souls of their deceased benefactors.—R. I. P.

New Mercy Hospital. A one-hundred bed hospital and training school for nurses will be erected this summer for the Sisters of St. Francis at Portsmouth, O. An enthusiastic drive for a fund of $200,000 was conducted by a committee of citizens headed by Mr. Edward T. Reed. In connection with the campaign for funds, a special letter to the public was inserted in a page advertisement of the local paper, which sought to overcome objections to such a campaign in the face of financial depression and also to overcome the opposition of doctors who might not be members of the hospital staff. The campaign was carried out with enthusiasm by the general public and came to a successful close with a large part of the fund raised.

Establishes Offices. Dr. Joseph F. Goeke of St. Louis, Mo., has established offices in Manistee, Mich., for the practice of medicine and surgery. Dr. Goeke was induced to locate in Manistee by the Sisters of Mercy to overcome a serious shortage of physicians. It was felt that an additional physician would relieve the burden for the rest of the profession.

St. Patrick's Party. A happy group of nurses met on Friday, March 17th, to decorate the recreation hall for a St. Patrick's Surprise Party. The decorations consisted of green paper, shamrocks, pipes and green flags. The hostesses wore green caps to match the rest of the decorations. Following the dancing and games, the guests were served with lunch.

New Sterilizing Room. The Northern Maine General Hospital at Eagle Lake, Me., has equipped a new sterilizing room. The room is somewhat larger than the old to take care of the increased amount of work carried on by the surgical department of the hospital.

Nurses' Home. The Northern Maine General Hospital, Eagle Lake, Me., has found it necessary to build or rent a modest home for the nurses of the institution. The large increase in the nurses' staff has made the present location inadequate for present and future needs.

Nurses' Home. The nurses' training school of Providence Hospital, Detroit, Mich., has begun the gathering of a fund for the new nurses' home. Several plans have been inaugurated to raise money. Among these were an "Easter Social" given April 19th, and a "Moonlight Excursion" given June 19th. Both are expected to bring large returns. The training school has admitted 68 new student nurses since September, 1921. The graduating class for 1922 comprises fifteen students.

Hospital Addition. An addition will be built for St. Francis Hospital, at Port Jervis, N. Y.

New Hospital Award Plan. A system of accounting whereby sectarian hospitals may be reimbursed for charity service rendered the public, has recently been worked out by Dr. John M. Baldy, head of the Pennsylvania Department of Welfare. Under the plan, reimbursements for actual service rendered will supersede blanket appropriations. The exact amount the state should pay will be estimated on the basis of the number of charity and part time patients treated by each institution. Previously, hospitals merely reported gross expenses. Dr. Baldy believes it will be legal to resume payments to sectarian institutions for actual service rendered.

FINAL CONVENTION PROGRAM

Washington Convention, C. H. A., June 20-23

INFORMATION.

1. Registration of Members of the Association:

(a) Registration will take place in McMahon Hall—Convention office of the Secretary-Treasurer of the Association. (b) Registration will begin at 8:30 A. M., Tuesday, June 20. (c) The members will please register and get their badges as early as possible. (d) The Sister, or other individual, who has been appointed by a hospital to represent it, will wear a white badge. (e) The white badge means the right to three (3) votes on every question. (f) Individual members will wear light blue badges. (g) The light blue badge means the right to one (1) vote on every question.

2. Registration of Everyone Who Attends the Convention:

(a) This will take place in McMahon Hall—Convention office of the Bruce Publishing Company. (b) The object of this registration is to get the names of all who attend the convention and publish them in the Bulletin that will be printed and distributed during the convention. (c) Please do not neglect this registration, so that the name of everyone may be published. The Bulletin is a great convenience for all.

3. Promptness in Attendance:

(a) The members will please be in their seats promptly at the scheduled opening time of each session. (b) This is a very important point, as tardiness delays the work of the convention, and late arrivals disturb both the speaker and the audience.

4. Promptness in Closing the Afternoon Sessions, Wednesday and Thursday:

(a) The afternoon sessions of these two days must close no later than 4:00 P. M. (b) It is necessary that this rule strictly be observed, in order that the Sisters may arrive at the Providence and the Georgetown University Hospitals respectively at 4:30 P. M.

5. Promptness and Order in the Program:

(a) The time-limits of papers and discussions will, please, be observed. (b) The program will be carried out as scheduled. (c) Interruptions, that are out of order, will, please, be avoided.

6. The Bureaus of Information on Hospital Problems:

(a) The policy of conducting such bureaus of information has been introduced this year with the purpose of making the conventions more practical for the Sisters. (b) The idea is to have the Sisters and others, who have problems to solve, visit the consultants in the various bureaus and, in a conversational way, acquire helpful information. (c) An endeavor has been made to have well experienced persons act as consultants, or advisors, in each of the bureaus.

7. The Hospital Meetings for the Sisters, Wednesday and Thursday:

(a) The policy of holding these meetings has been introduced also with the purpose of affording the Sisters more practical advantages at the convention. (b) The object is to have the Sisters exchange ideas, by means of actual demonstrations, on various phases of nursing, etc. (c) Obviously the success of these meetings must depend, for the greater part, on the initiative of each Sister and the active cooperation of all.

8. The Convention Conferences, Wednesday, June 21:

Past experience teaches that the important points brought out in these conferences should so clearly and deliberately be stated that the secretary of each conference can make an accurate record. Manifestly this is necessary, in order that the value of the points be not lost and the speakers be not misquoted.

9. Doctors' Sessions, Wednesday and Thursday:

(a) The morning clinics, at the Providence and the Georgetown University Hospitals, are another innovation this year. It was not intended that these clinics be limited to the observation of surgical operations and similar medical work, but that they include also the other hospital factors of interest. (b) Because of these morning clinics, the doctors' convention conference will not take place until the afternoon session, Wednesday, June 21. (c) This year the nurses are invited to the doctors' night meeting, Wednesday, June 21, at 8:00 P. M., in the auditorium of the Medical Society of the District of Columbia, 1718 M Street, N. W.

10. Railroad Transportation:

(a) The members are reminded to make their return reservations no later than Thursday, June 22. (b) However, railroad agents will be at the convention Thursday and Friday, June 22 and 23, to help in making reservations.

11. Commercial Exhibits:

(a) This year the commercial exhibits are unusually extensive, interesting, and instructive. (b) The members are urged to visit the exhibits as much as possible. See list of exhibitors herein printed.

B. F. McGrath, M. D.
Secretary-Treasurer.
Chairman of Program Committee.

June, 1922.

SPECIAL: BUREAUS OF INFORMATION ON HOSPITAL PROBLEMS.

(In various rooms of the University.)

NOTES.

1. Each bureau will be conducted by consultants, or advisors.

2. The object is to have the members of the Association visit the various bureaus for the purpose of getting advice on the different hospital problems.

3. Questions should be presented to the consultants as clearly and briefly as possible, in order that all desiring information may be served.

4. All of the bureaus will be conducted at the same time.

5. An endeavor will be made to publish a list of the consultants at the convention.

The following are the days and hours when the bureaus will be in operation:

Tuesday, June 20—4:30 to 6:00 P. M.

Wednesday, June 21—8:30 to 9:45 A. M.; 1:00 to 1:45 P. M.; 7:00 to 8:00 P. M.

Thursday, June 22—1:00 to 1:45 P. M.; 7:00 to 8:00 P. M.

Friday, June 23—8:00 to 8:45 A. M.

Subjects.

1. General Problems of the Hospital. 2. Religious Practices in the Hospital. 3. Hospital Management. 4. Training School. 5. Dispensary. 6. Dietetics. 7. Medical Social Service. 8. Records. 9. Nursing. 10. Floor Service. 11. Operating Room. 12. Laboratories. 13. Doctors' Staff and Interns. 14. Legal Problems of the Hospital.

Other bureaus may be added to this list if suggested at the Convention. This being the first trial of the policy of Information Bureaus, it should be viewed as a basis on which to build in future conventions.

PROGRAM.

First Day—Tuesday, June 20.

Morning Session.

10:00 A. M. MASS AND SERMON, Franciscan Church. Celebrant, Most Rev. Sebastian G. Messmer, D. D., D. C. L., Archbishop of Milwaukee. Sermon by Most Rev. Michael J. Curley, D. D., Archbishop of Baltimore.

OPENING OF THE CONVENTION.

Auditorium of the Gymnasium, University.

11:30 A. M. ADDRESS OF WELCOME
Rt. Rev. Thomas J. Shahan, S, T. D., J. U. L., LL. D., Rector, Catholic University of America, Washington, D. C.

12:00 Noon OFFICIAL CONVENTION PHOTOGRAPH. All are requested to be present.

Afternoon Session.

(Auditorium of the Gymnasium, University.)

2:00 P. M. PRESIDENT'S ADDRESS. Rev. Charles B. Moulinier, S. J., Marquette University, Milwaukee, Wis.

Symposium: Hospital Organization.

2:30 P. M. PAPER: "Organization of the Hospital as a Whole." A Sister.
2:45 P. M. PAPER: "The Scientific Organization of the Hospital." Sister M. Cephas, Mercy Hospital, Cedar Rapids, Iowa.
3:00 P. M. PAPER: "The Economic Organization of the Hospital." Sister M. Innocent, Mercy Hospital, Pittsburgh, Penna.
3:15 P. M. PAPER: "The Administrative Organization of the Hospital." Sister M. Regina, Mercy Hospital, Wilkes-Barre, Penna.
3:30 P. M. DISCUSSION (Each limited to five minutes): Opened by Sister M. Amadeus, St. John's Hospital, Cleveland, Ohio; Sister M. Rodriguez, Georgetown University Hospital, Washington, D. C.; Sister M. Laurentine, St. Francis Hospital, Pittsburgh, Penna.
3:45 P. M. PAPER: "Factors in the Proper Care of the Tuberculous." Charles O. Giese, M. D., Glockner Sanitorium, Colorado Springs, Colo.
4:00 P. M. Adjournment to 10:00 A. M. Wednesday.
7:30 P. M. MEETING of the Officers and Directors of the Sectional Conferences (State, District, or Provincial). All Sisters attending the Convention are invited to this meeting in the Auditorium of the Gymnasium, Catholic University.

Second Day—Wednesday, June 21.

8:30 A.M. DOCTORS' CLINICS. Providence Hospital (Daughters of Charity of St. Vincent de Paul), Second, Third, D and E Streets, S. E.

Morning Session.

(In various rooms of the University.)

10:00 A. M. CONFERENCES.

Notice.

1. The Chairmen will be appointed by the President, Rev. Charles B. Moulinier, S. J.
2. Each Chairman will appoint a Secretary.
3. The Secretary will make a record of the principal points brought out in the conference and be prepared to give a brief summary of these points at the opening of the afternoon session.
4. Each Chairman will prepare a report of the transactions of his or her conference, and read this report at the general meeting Friday morning, opening at 9:00 o'clock.
5. Questions for discussion will be found in the Questionnaire Book, compiled from questions and suggestions submitted by the Sisters and others.
6. The conferences will be held in various buildings of the University.
7. The conference rooms will be numbered as follows:

Conference I—Mothers Provincial and Superior; Superintendents; Supervisors and instructors of Training Schools; Heads of Floors.
Conference II—Operating Room Nurses; Anesthetists.
Conference III—Laboratory Directors and Technicians.
Conference IV—Dietitians.
Conference V—Supervisors of Records and their Assistants.
Conference VI—Hospital Social Service and Dispensary Workers.
Conference VII—Doctors. Because of the morning clinics, the Doctors' Conference will not open until the afternon session, 2:00 P. M.
Conference VIII—Graduate Nurses (not Sisters).
Conference IX—Diocesan Directors; Chaplains; Retreat Masters; Sodality Directors.

Afternoon Session.

(In the same rooms as were the Morning Conferences.)

2:00 P. M. CONFERENCES CONTINUED.

Note: At the opening of this session the Secretary will present a brief summary of the principal points brought out during the morning session.

4:00 P. M. ADJOURNMENT until 10:00 A. M. Thursday.

Note: Each Secretary will prepare a report of the day's transactions of his or her conference, these reports to be presented by the Chairmen at the general meeting Friday morning, opening at 9:00 o'clock. Each report will be limited to ten (10) minutes.

4:30 P. M. SISTERS' MEETING at Providence Hospital, (Daughters of Charity of St. Vincent de Paul). Second, Third, D and E Streets, S. E.

Particular demonstrations; open house for inspection, with all departments in action; and an informal reception.

Committee in Charge: Sister M. Berchmans, Superior of Providence Hospital; Sister Rose Alexius, Good Samaritan Hospital, Cincinnati, O.; Sister M. Madeleine, St. Mary's Hospital, Minneapolis, Minn.; Sister M. Veronica, Mercy Hospital, Chicago, Ill.

Night meeting of Doctors and Nurses in the Auditorium of the Medical Society of the District of Columbia, 1718 M Street, N. W.

PROGRAM.

8:00 P. M. PAPER, (illustrated with moving pictures): "Demonstration of the Birth Process." John F. Moran, M. D., Professor of Obstetrics, Georgetown University School of Medicine, Washington, D. C.
8:45 P. M. PAPER, (illustrated with lantern slides): "The Nursing Care of the Child as shown in Art and Archeology." John Foote, M. D., Professor of Pediatrics, Georgetown University School of Medicine, Washington, D. C.

Third Day—Thursday, June 22.

8:30 A. M. DOCTORS' CLINICS, Georgetown University Hospital (Sisters of the III Order of St. Francis), Thirty-fifth and N Street, N. W.

Morning Session.

(Auditorium of the Gymnasium, University.)

10:00 A. M. SYMPOSIUM:
(1) Fundamentals of Medical Activities.
(2) Functions of the General Hospital."

(1) "Fundamentals of Medical Activities. Surgical Laboratories, Marquette University School of Medicine, Milwaukee.
2. "Fundamentals of Medical Activities," Rev. C. B. Moulinier, S. J., Marquette University, Milwaukee.
3. "Extra Hospital Activities," Rev. John M. Cooper, D. D., Catholic University of America, Washington, D. C.
4. "Administration," Sister M. Benita, Holy Cross Hospital, Salt Lake City.
5. "Research, Education, and Library," John T. Bottomley, M. D., Surgeon, Carney Hospital, Boston.
6. "The Patient's Entrance," Raymond P. Sullivan, M. D., Surgeon, St. Vincent's Hospital, New York City.
7. "The Diagnostic and Therapeutic Center," Chas. H. Nielson, M. D., Professor of Medicine, St. Louis University School of Medicine, St. Louis. H. W. Loeb, M. D., Dean, St. Louis University School of Medicine, St. Louis.
8. "Psychiatry and Neurology," A. C. Gillis, M. D., Professor of Neurology and Clinical Psychiatry, University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore.
9. "Physiotherapy," G. P. Muller, M. D., Surgeon, Misericordia Hospital, Philadelphia.
10. "Dietetics," Mrs. Agnes O'Dea, Chief Dietitian, Johns Hopkins Hospital, Baltimore.
11. "Laboratories," R. A. Kilduffe, M. D., Director of Laboratories, Pittsburgh Hospital (Sisters of Charity), Pittsburgh.
12. "Nursing," Miss Lucy Minnegerode, Superintendent of Nurses, U. S. Public Health Service, Washington, D. C.
13. "Medical Social Service," Miss Elizabeth Cosgrove, Director of Social Service Department, Mercy Hospital, Pittsburgh.
14. "Staff Meeting, Records and Museum," F. D. Jennings, M. D., Surgeon, St. Catherine's Hospital, Brooklyn.
15. Resumé, Rev. C. B. Moulinier, S. J.

Afternoon Session.

(Auditorium of the Gymnasium, University.)

Business Meeting.

2:00 P. M. Report of President, Rev. Charles B. Moulinier, S. J.
Report of Secretary-Treasurer, B. F. McGrath, M. D.
Report of Chairman of Committee on Ethics, Rev. M. P. Bourke.
Report of Chairman of Committee on Stan

dardization, Rev. P. J. Mahan, S. J.

Report of Director of Sectional Conferences, Rev. Geo. A. Metzger.

Report of Director of Diocesan Supervisors, Rev. John P. Boland.

Election of Officers for the year 1922-1923.

4:00 P. M. Adjournment until 9:00 A. M. Friday.

4:15 P. M. Meeting of the newly elected Executive Board.

4:30 P. M. Sisters' Meeting at Georgetown University Hospital. (Sisters of the III Order of St. Francis, Thirty-fifth and N Street, N. W.

PROGRAM:

Particular demonstrations; open house for inspection, with all departments in action; and an informal reception.

Committee in Charge: Sister M. Illuminata, Superior of Georgetown University Hospital; Sister Rose Alexius, Good Samaritan Hospital, Cincinnati, O.; Sister M. Madeleine, St. Mary's Hospital, Minneapolis, Minn.; Sister M. Veronica, Mercy Hospital, Chicago, Ill.

Fourth Day—Friday, June 23.
Morning Session.

9:00 A. M. Reports of Chairmen of the Wednesday Convention Conferences. Each report will be limited to ten (10) minutes.

10:30 A. M. PAPER: "Hospitals as a Missionary Agency," Floyd Keeler, Field Secretary, Catholic Students' Mission Crusade, Washington, D. C.

10:45 A. M. PAPER. "The Catholic Lay Medical Apostolate on the Foreign Missions," Paluel J. Flagg, M. D., New York City, N. Y.

11:00 A. M. Reports of Committees appointed by the President during the Convention.

Unfinished Business.

12:00 Noon Convention Adjourned.

Afternoon.

Trip to Mount Vernon, Sight-seeing, or a visit to the Walter Reed Hospital to observe work of rehabilitation.

MEMBERSHIP OF THE LOCAL COMMITTEES, DISTRICT OF COLUMBIA.

DR. JOHN F. MORAN, Chairman.
DR. ROBERT YOUNG SULLIVAN, Secretary.

Providence Hospital: Dr. Robert Young Sullivan, Dr. J. Lawn Thompson, Dr. Charles C. Marbury, Dr. William G. Young, Dr. Charles Stanley White, and Sister M. Berchmans.

Ladies' Auxiliary of Providence Hospital: Miss Ella Loraine Dorsey, President; Mrs. Charles K. Koones, and Mrs. James A. Cahil, Jr.

Nurses' Alumnae Association of Providence Hospital: Mrs. Mary V. Healy, President; Miss Anna E. Heberle, and Miss Catherine J. M. Vanderloo.

Georgetown University Hospital: Dr. John F. Moran, Dr. John A. O'Donoghue, Dr. Charles I. Griffith, Dr. Thomas S. Lee, Reverend Francis A. Tondorf, S. J., and Sister M. Illuminata, O. S. F.

Ladies' Board of Georgetown University Hospital: Mrs. Isaac Gans, President; Mrs. George Tully Vaughan, and Mrs. Milton E. Ailes.

Alumnae Association of Georgetown University Hospital Training School for Nurses: Miss Mary E. Graham, President; Miss Julia M. Lennon, and Miss Mary E. Butler.

OFFICERS AND EXECUTIVE BOARD 1921-1922.

Honorary President—MOST REV. SEBASTIAN G. MESSMER, D. D., D. C. L., Milwaukee, Wis.

President—REV. CHARLES B. MOULINIER, S.J., Marquette University, Milwaukee, Wis.

Active Vice-President—REV. P. J. MAHAN, S. J., Loyola Medical School, Chicago, Ill.

Secretary-Treasurer—BERNARD FRANCIS McGRATH, A. B., M. D., F. A. C. S., Marquette University School of Medicine, Milwaukee, Wis.

EXECUTIVE BOARD.

LOUIS D. MOORHEAD, M. D.
Mercy Hospital, Chicago, Ill.

REV. M. F. GRIFFIN,
St. Elizabeth's Hospital, Youngstown, Ohio.

MOTHER M. L. DUGAS,
Superior General, Grey Nunnery, Montreal P. Q., Canada.

F. S. WILEY, M. D., F. A. C. S.,
Fond du Lac, Wis.

SISTER M. VERONICA,
Mercy Hospital, Chicago, Ill.

SISTER ROSE ALEXIUS,
Good Samaritan Hospital, Cincinnati, Ohio.

MOTHER M. MADELEINE,
St. Mary's Hospital, Minneapolis, Minn.

HEADS OF DIVISIONS.

Supervisor of Diocesan Directors' Division

REV. J. P. BOLAND, PH. D., D. D., D. C. L.
Buffalo, N. Y.

Director of State, District or Provincial Conferences

REV. GEO. A. METZGER,
Brooklyn, N. Y.

ST JOHN'S HOSPITAL, CLEVELAND, OHIO.

Surgical Technique Employed at United States Public Health Service Hospital No. 35

(Conclusion)

7. Preparation of the Operating Room.

The most important part of the operating room technique, at least as far as the nurses are concerned, is the "setting up", or the convenient and scientific arrangement of things for the operation. All preceding explanatory paragraphs in this paper have been devoted to information that would tend to clarify and lead up to this important process, and, in fact, all of our work is considered secondary to this phase of our technique which deals so intimately with the operation itself. The technique employed here is progressively explained and the successive steps should be followed throughout by constant reference to the appended drawing (Fig. 3) of the operating room interior. Although a progressive presentation by stages is attempted, it must be admitted that, as the preparation is performed by various members of the personnel, it cannot follow an exact and invariable outline. However, the central scheme to accompany the nurses (assisted by the orderlies) through a day of operating room work is not deviated from to any great extent.

The day nurses arrive in the ward for duty at 7 a. m. The cabinets and instrument cases are opened, and the steam is turned on in the sterilizers. Table "A", unsterile, which can be conveniently named a service table, is usually set up first. Gallon supply bottles of the following solutions are set out: 95 per cent alcohol, instrument alcohol ("used" 95 per cent mixed with carbolic), and creolin solution. On this table are usually kept cotton applicators, a small bottle of iodine, and a can of used ether for the final preparation of the skin for operation. Gauze for the post-operative dressing is also kept on this table. On the corner of table "A" two instrument pans (unsterile) are placed as indicated in the diagram; the pan nearest the sterile instrument table is filled with pure carbolic acid, and the other with 95 per cent instrument alcohol. In the pure carbolic acid pan are placed sharp-edged instruments, glass syringes, suture tubes, and other articles that require this method of sterilization. All things to be thus sterilized are placed in the pure carbolic acid at the same time the other instruments and supplies are put in the water or steam sterilizers. This insures at least a twenty minutes' bath in the antiseptic. At the end of this time, or whenever they are needed, they are lifted out of the carbolic by means of sterile forceps and transferred to the instrument pan containing the 95 per cent alcohol. After they have been thoroughly washed in the alcohol they are removed to the sterile water pan on table "D" and given a cool, sterile water immersion. After this they are ready for use and are placed in position on the instrument table or given directly to the operator.

While table "A" is being set up by one nurse, another nurse (as a rule, the sterile nurse, before she scrubs up) places all articles to be sterilized for the day's operations in the instrument and utensil compartment of the steam sterilizer. These materials for sterilization are divided between the two compartments, instrument and utensil, as may be convenient, according to their size and nature. In the utensil compartment are placed the following articles: six white granite solution pans, two large white granite pitchers, two emesis basins, four large square

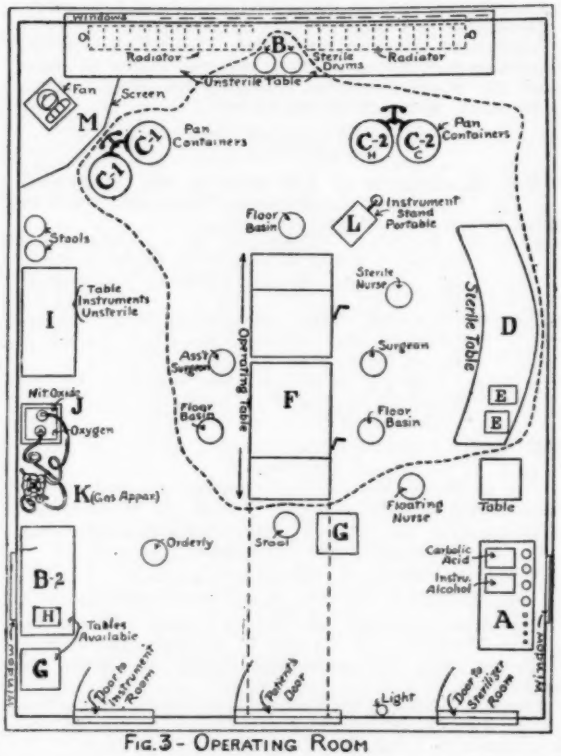


FIG. 3 - OPERATING ROOM

pans, etc. In the instrument compartment are placed the following articles: four two-ounce medicine glasses, several medicine droppers, and the instruments to be used during the operation. It is to be noted here that during this time when the instruments, etc., are selected and the sterilizers are filled, this phase of the work not only involves the automatic action of the nurses in "placing things" but, more important, it incorporates the play of visual and deep receptors; that is, during this time the sterile nurse has ample opportunity for foresight in the proper selection and the final critical checking-up observation of the materials to be used.

The drum containers and packages of sterile linen are brought out from the cupboards and placed on the unsterile shelf over the radiators, marked "N" in the diagram, by "floating" nurses. Other secondary and minor arrangements, somewhat dependent upon the character of the day's operations, include the placing or adjustment of unsterile supplies and equipment.

The nurses usually go to breakfast at this time, 7:30 a. m. When they return, approximately one-half hour later, the instruments, etc., are sufficiently sterilized (20 minutes being the minimum time required in our practice) for their removal to the scene of operation.

From this time on a division of labor takes place which separates the preparatory operating room technique into the duties of the sterile and nonsterile nurse. The designated sterile nurse now scrubs up according to the

general method described in the former section of this report. The nonsterile nurse drapes the basin stands, "C" with sterile linen and places in the basin holders two of the large white enamel basins from the utensil sterilizer, filling them, respectively, with one-helf per cent creolin solution and 60 per cent alcohol solution. She now opens the drum containers and some of the sterile packages of towels, sheets, sponges, etc., thus making all such supplies available to the sterile nurse. The sterile nurse, who is by this time "scrubbed up," soaks her hands in the above solutions of creolin and alcohol and proceeds to drape the long instrument table, "D," and the portable table, "L," with sterile towels and sheets. The articles from the instrument and utensil sterilizers are now brought out and arranged in their places as follows: Two white granite solution-pans (on stand marked "C-2" on diagram) for the hot and cold sterile water; two emesis basins, placed on table "B" as indicated; two of the large square pans are placed on the end of table "D," to be used as instrument or suture-tube receptacles. Articles remaining are left in the sterilizer for any emergency or later demand that may occur.

The way the instruments are placed in the sterilizer determines the order in which they are to be removed to the operating room. How the instruments are placed in the sterilizer is determined for the most part by the character of the operation. For instance, if the operation is a bone operation, which necessarily presupposes the use of a large number of heavy instruments, the instruments are placed directly on the bottom tray of the sterilizer and removed to the operating room by lifting out and carrying the entire tray to the scene of operation. Again, if only a few small instruments are to be used, they may simply be wrapped in a towel, which is picked up with sterile forceps and transferred to a sterile pan, and the pan is taken to the operating room within reach of the sterile nurse, who arranges the instruments on the sterile table "D".

When everything necessary for the operation has been brought from the sterilizer, the sterile nurse occupies herself with arranging these articles on tables "D" and "L" in the most convenient way possible. The general method of arrangement has been indicated as far as possible on the diagram, although it can readily be understood how this particular method may be varied within wide limits. The general principle governing the arrangement of instruments is one of convenience and quick utilization. The details of this technique adjust themselves to the personnel involved and the determining characteristics of the operation. The preparation of sutures and a last critical survey of the ensemble complete the duties of the sterile nurse until the actual arrival of the patient.

In the interim before the arrival of the patient, the nonsterile nurse is kept busy with the performance of many secondary but nevertheless important duties. The ether anesthetic table, whether the operation is to be under local or general, must be prepared. On this table are placed the following articles: Ether, ether masks, tongue forceps, trachea tube, mouth gag, folded towels (wet and dry), jar of vaseline, small cotton pledgets for covering the patient's eyes, and patient's cap. Ether cans are prepared by running a safety pin through the soft metal top, and the ether is given by the drop method. The table thus prepared is indicated in Figure three as "G". When local anesthetic is to be given, or general is not needed for any other reason, the table is kept in the position indicated in the diagram. However, when a general anesthetic is to be used, it is moved to the position indicated by the dotted line, i. e., to the right-hand side of the anesthetist, who is at the head of the operating table.

Local anesthesia is used in about seventy per cent of the cases operated upon at this hospital, and the proper preparation of the solutions is of considerable importance. The cotton stoppers of the bottles containing the solutions are covered with a gauze sponge, held in place by a rubber band placed around the neck of the bottle. The solutions used are freshly prepared and boiled each time a local anesthetic is used in major operations.

The operating room is equipped with two large tanks of oxygen and nitrous oxide (1,280 gallons each), and another apparatus with smaller tubes of the same gases for emergency. The anaesthetizing apparatus is indicated in Figure three as "J" and "I". It must be frequently tested by the surgeon (or the nurse, if she understands) to determine the amount of gas on hand and the workable condition of the apparatus. In case it is asked for during an operation, it usually becomes the duty of the nurse to bring it into position and to connect the electric wall plug for warming the gas.

Table "I" in the diagram is an unsterile table which is utilized for a miscellaneous assortment of articles that are needed or may be needed during the operation. Among these are found tongue depressors, adhesive tape, bandage rolls, etc.

A hypodermic tray, "H," is prepared and placed on the unsterile service table, "B." The tray is made up as follows: On large spoon, alcohol lamp, sterile water, covered jar containing cotton, pledgets, 2 medicine glasses partially filled with alcohol (hypodermic needles are kept in one and hypodermic syringe in the other), and the different tubes of hypodermic tablets that will likely be needed.

The operating room air is kept in circulation by a fan placed behind the screen "M" in the right corner of the operating room. The fan keeps the air alive, while the screen diffuses the flow and prevents the creation of direct air currents.

This practically completes the description dealing with the preparation of the operating room prior to the arrival of the patient. Variations of routine technique that may occur as the result of unstandardized and perhaps insignificant phases of the work, will be briefly commented on in the final section of this paper.

When the patient is brought in, the nonsterile nurse, who should be informed as to the character of the operation, takes charge of placing the patient in the required position, the arrangement of unsterile coverings and the adjustment of pillows, sandbags, or other props. She then removes the alcohol pack, and the surgeon's assistant applies the solution for final sterilization of the skin, as previously described. The sterile nurse (or the assistant) then drapes the patient and the table with sterile linen.

8. Division of Labor and Cooperation Among Personnel.

With the beginning of the operation the period of preparation ends and the duties of the sterile and nonsterile nurse depend upon the progress of the operation. The duties a nonsterile nurse may be called upon to perform during the operation are not specific and, depending as they do upon the development of anticipated wants, must be spoken of in a general way.

Just before the actual operation begins, the basins on "C-2" stand are filled with cold and hot sterile water, and the shallow pan on table "D" is filled with cold sterile water. During the operation the nonsterile nurse may be called upon to change the water because of contamination or merely as a precautionary measure.

Soiled linen, contaminated material, sponges, and instruments dropped on the floor must be removed by the nonsterile nurse or, by her direction, by the orderly. In this connection a constant watch should be kept by her as to the preservation of sterility and the uninterruped progress of the operation. This, when thus briefly stated, does not seem to imply much; but in reality, through her neglect or inability to perform this function, disaster may occur. With the concentration of the surgeons and the

sterile nurse upon the performance of the operation, the general supervision of the smooth running of things naturally falls to the nonsterile nurse. Her ability and enthusiasm to act in this capacity gauge her success as an operating room nurse. Other calls for emergency may develop; the patient may "go bad," as they say, and his condition call for stimulant by hypodermic or subcutaneous saline injection. In this case it is the nonsterile nurse who prepares and administers the medication.

There has been continued reference throughout this paper to the phases of work participated in by the sterile nurse. However, for the sake of clarity, her duties may be briefly summarized as follows: She selects all instruments, catgut, needles, and other material likely to be used in the operation; she inspects and groups the instruments and oversees their complete sterilization; because her work during the operation requires a position in the midst of the sterile field, she scrubs up with the same thoroughness as the surgeon; when she is completely sterile she sets up the sterile tables and arranges the materials as they will be needed; when the chief surgeon and his assistants arrive, she assists them in putting on their gloves; during the operation her attention is directed solely to obeying the demands of the operators. She is also expected to keep a numerical account of the sponges and instruments used, to prevent the possibility of any being left where they should not be. The technique of the sterile nurse during the operation should not consist of mere mechanical effort, but of a prompt obedience accelerated by intelligent anticipation. Her actual duties vary, as do those of the operators, according to the nature of the operation. Her technique, such as the handling of instruments, the preparation and cutting of sutures, and the degree of help required, seems to reach a happy medium according to the operator's own particular methods and the nurse's previous training.

Problems of operating room technique, such as standardizing the names of instruments, the elimination of reduplication effort, and experimentation with new forms of cooperation, have ben studied seriously, but need not be elaborated here.

STAFF DOCTORS' NEWS.

Dental Clinic. A modern dental clinic has been established in Mercy Hospital Dispensary at Baltimore, Md. Dr. Norval McDonald has been appointed director of the clinic and Dr. Leo Walzak associate.

The members of the staff gave a dance at the armory for the purpose of meeting the expenses of the clinic. The armory was decorated for the occasion and music was furnished by a large orchestra. The affair was well attended by an enthusiastic number of merrymakers and resulted in a financial success. One of the features of the dance was the drawing for an automobile, which was won by Mrs. E. P. Smith, wife of Dr. E. P. Smith, Mercy Hospital. The active management of the dance was in charge of a committee consisting of Dr. Charles E. Brack, chairman, Dr. Alexius McGlannan, Dr. W. W. Requardt, Dr. A. Samuels, and Dr. W. F. Zinn.

The clinic is active and much good is being accomplished for those who are financially unable to obtain such service.

Hospital Staff Meeting. The staff of St. Francis Hospital at Wichita, Kans., held its annual meeting on May 2nd, at which the following officers were elected: President, Dr. J. G. Dorsey; Vice-President, Dr. J. F. Gsell; Secretary, Dr. E. E. Tippin; Treasurer, Dr. C. N. Johnson. New members of the staff admitted were Dr. J. G. Missildine, Dr. J. E. Wolfe, Dr. A. P. Gearhart and Dr. R. Boone.

The following executive committee was appointed: Dr. J. L. Evans, Dr. T. Jager and Dr. T. Walker Weaver.

Head of Staff. Dr. C. F. Stough has been reelected head of the St. Francis hospital staff at Colorado Springs, Colo.

Staff Members Give Talks. On Wednesday, May 10th, seven of the staff members of St. John's Hospital, Fargo, N. D., addressed the women of the city, including mothers, school nurses and teachers. The lectures, which were brief, were given in the interests of "child welfare week."

On Saturday, May 13th, there was a clinic for children. At this clinic several members of the staff gave their services in examining nearly one hundred children. A dentist and three specialists were present to give special attention to eye, ear, nose and throat defects. Both the lectures and clinic were held in the classroom of St. John's Hospital.

On Thursday evening at the regular staff meeting a great deal of interest was aroused by the discussion of two cases of encephalitis. One death resulted and one case was still under treatment, though unimproved. The ailment, which was prevalent in the locality for several months, gave rise to interesting and valuable questions and answers relative to the disease. Much of benefit to each member of the staff was received by all present.

ANNUAL LUNCHEON OF THE DOCTORS' CLINIC AT ST. ELIZABETH'S HOSPITAL, YAKIMA, WASH.

The Value of "Visualizing" Established Scientific Data,[1]

or the Importance of "Little Things"

Georgine Luden, M. D., Ph. D., First Assistant in Cancer Research, Mayo Foundation, Rochester, Minnesota

A witty Frenchman once said: "There is but one step from the sublime to the ridiculous." We shall reverse the order of that old proverb tonight. I am going to call your attention to four points. The first two are funny, if not actually ridiculous: the last two are serious and show the bearing of "visualized" data on great medical problems. These points are: (1) the commercial value of the ingredients of which the body is made; (2) what bacteria and bacilli think of us; (3) the concentration of carbon monoxide in automobile exhaust gas; and (4) the relation of "visualized" data to the cancer problem.

The commercial value of the body constituents. The complaint is often heard that we live in a "commercial" age. At any rate we almost involuntarily ask "How much does it cost?" or "What is it worth?" when we are shown some new thing. You will recall that sometime ago we discussed the size of the body cells and the ludicrously small amounts of the chemical ingredients which "keep the body going." It may be of interest to find out how much the ingredients of which the body is made would cost at present-day prices. A big industrial company, The Marathon Paper Mills, published the following estimate of the divers ingredients contained in the body:

"Fat enough for seven bars of soap;
Iron enough for a medium sized nail;
Sugar enough to fill a shaker;
Lime enough to white-wash a chicken coop;
Phosphorous enough to make 2200 match-tips;
Magnesium enough for a "dose" of magnesia;
Potassium enough to fire a toy cannon;
Sulphur enough—to rid a dog of fleas!"

The list is by no means complete and the data are somewhat indefinite: the size of the dog and the number of his tormentors, for instance, are left to the imagination. The commercial value of this whole collection given as 98 cents, which is cheap enough, recalls the "bargain sale" and is not likely to give any one a "swelled head."

(2) *What bacteria and bacilli think of us.* You all know that bacteria and bacilli are the tiny one-cell organisms, which in many instances have proved to be the cause of certain diseases. Some of them are just like little round dots, in which case they are called cocci, others are more like very minute sticks or lead pencils and are then called bacilli, a third variety look like small snakes or miniature cork-screws and are called spirochetes. When the cocci or dots are grouped together so as to look, under the microscope, like a string of beads, we give them the name of "streptococci," when we find them in clusters, like a bunch of grapes, we refer to them as "staphylococci" because the Greek word "staphylos" means a bunch of grapes. Both streptococci and staphylococci are responsible for the formation of pus; they swarm in the socalled "infected" wound and cause no end of trouble to the physician, the nurse, and last but not least to the patient; the disease called Erysipelas is produced when myriads of streptococci establish themselves in the skin, mostly the skin of face and arms. A very few instances will suffice to recall to you the deadly work done by bacilli and spirochetes: I need but mention the bacillus of typhoid fever, of diphtheria, of pneumonia, of tuberculosis, and the so-called "pale spirochete", the cause of syphilis. All of these enemies of the human race, are so small that we have to magnify them under the microscope no less than 1000 times to be able to see them at all, yet they do a powerful lot of mischief as we all know, and kill innumerable persons. Being one-cell organisms bacteria and bacilli have neither arms nor legs, or brains, yet they have a very decided opinion of their own about us human beings. I am sorry to say that this opinion is very poor as well as disrespectful, considering that fact that the human race is often spoken of as "the masters of creation." Bacteria, in fact, look upon us as nothing else but "things good to eat," more or less as we look upon a potato or a turnip. This brings me to a point of great practical importance.

Everybody knows that when our food "agrees with us," as we call it, we are well, and that when we are well, we are also happy and amiable. But if our dinner has disagreed with us for some reason, we are very apt to feel miserable and to be cranky and disagreeable in dealings with others. The same thing applies to bacteria and bacilli. When such a germ happens to settle down in a healthy person he finds a nice, tasty dinner, that he likes and which agrees with him. As the result his temper is amiable: he behaves as a polite visitor and causes little or no trouble. In fact his host or hostess may not even know that he is there. If, however, the person which the germ chooses to feast upon does not represent a good dinner, the germ very soon looses his temper: he becomes poisonous and his host suffers by becoming very ill. That may sound like a fairy tale, and quite "unscientific," but we have scientific proof as well as practical evidence that it is true nevertheless. It has been proven by innumerable experiments, that the characteristics of many bacteria can be changed by growing them on different culture media, , thus: for instance a streptococcus, which causes red blood corpuscles to dissolve, being "hemolytic" as we call it, when grown on one type of medium in a glass dish, will be turned into a "non-hemolytic streptococcus," when made to grow on a different mixture.. Many other instances might be quoted. Practical experience has shown that during an epidemic a number of persons do not get ill with the disease, although they are furnishing "room and board" to the very germs that cause the disease: these people are generally referred to as "carriers;" swarms of typhoid bacilli may be found in the gall-bladder of the "typhoid carriers," millions of diphtheria bacilli inhabit the throat of the "diphtheria carrier;" neither of them contracts the disease, because the germs are quite satisfied with their living quarters. The carriers, however, are a danger to the community, because they may very easily hand over some of their germs to people who do not happen to "taste as nice" and who by that very fact will upset both the digestion and the temper of the germ

[1]Given before the Nurses' Training School of St. Mary's Hospital, Rochester, Minn., Nov. 1, 1921.

with the result that they promptly "succumb to the infection." Statistics dealing with tuberculosis have proved, that only *three* out of one hundred persons, who had never shown any signs or symptoms of tuberculosis infection, were really free from tuberculosis. In other words, ninety-seven out of every hundred people who appear to be entirely free from tuberculosis were found at autopsy to have some tubercular lesion somewhere in their anatomy: maybe an old, healed tuberculous gland, maybe a small spot in the corner of one lung. Now none of these people had ever really "had tuberculosis," to their own or anybody else's knowledge. Yet they all had old tuberculous lesions, which showed that at some time or other the bacillus of tuberculosis had taken up his abode within their bodies. Why do they not get the disease? I think that the answer is this: their bodies furnished the bacillus with a kind of dinner that kept him in an amiable frame of mind and did not make him feel like going on the war-path, so he just sat in that corner contentedly till (to make a sort of a fairy-tale ending to the story) he simply died "respected," if not lamented, and his host's body made a little cemetery around the remains. These little cemeteries were the things we found at autopsy in the many hundreds of cases from which the statistics were made at the Pathologic Institute in Munich, when I was working there.

All of these facts tend to show how important it is to keep our bodies "healthy" as we call it; for when our bodies are healthy we simply represent a nice dinner for any bacillus that we happen to run into, and the bacillus behaves as an amiable guest instead of like an angry invader and we do not "get" the disease which the bacillus can cause. Not all diseases are caused by bacilli, however, there are types of illness in which the bacilli are entirely free from blame, namely in the diseases caused by poisons: lead poisoning for instance, in which the poison is put into the body from *without*. In other cases the poison, which does the harm, may be supplied from *within:* in those cases some part of the body machinery has got damaged, does bad work in consequence and the production of "poisons" results. The manifestly "poisoned condition" of the patient in *diabetic coma*, when the pancreas is doing careless work, or in *uremic coma*, when the kidneys are damaged beyond repair, may serve as an illustration of the latter type of illness.

Now it is a well known fact diabetic patients are very apt to contract "intercurrent" diseases—tuberculosis for instance: that their wounds heal badly and are specially likely to "get infected," unless the greatest care is taken to avoid it. So that we are justified in concluding that a poisonous condition of the body, no matter whether the poison is made inside or outside the body, will turn the person into an *un-palatable* dinner for the many bacilli, which we are all likely to run into, and will therefore make such a person very likely to "catch" the disease, which a given bacillus can cause. This is a very important point, which I want you all to remember very carefully and to remember in such a way that it is not just a "mere idea," but something "very real" to you, *everything which damages or upsets the delicate body machinery is capable of turning us into the kind of dinner which bacilli do not like, which makes them peeved and aggressive, instead of contented and harmless.* Bacilli are very tiny organisms and, as we have seen, they are likely to resent "little" changes in the composition of their dinner. This is another instance of the "importance of little things," which is also shown by the next thing to which I want to call your attention tonight, namely

The amount of carbon monoxide in automobile exhaust gas. "Carbon Monoxide" is merely the scientific title of the thing which, in every day life, we refer to as "coal gas." It is an extremely dangerous and deadly gas, responsible for a great number of deaths every year and all over the world. It is dangerous and deadly, not because it is actually "poisonous," but because it interferes with the proper working of this delicate body machinery of ours. If you stick a pin into the "works" of your watch, the result is likely to be disastrous—both to the left in, the greater the damage that is apt to result. "Coal watch and to the owner's pocketbook! The longer the pin is gas" harms the body in much the same manner: it puts a spoke into the body machinery. If you take that pin out of your watch very quickly, the watch may continue to run properly. But if you repeat the operation often enough, sticking in the pin and removing it a great many times in succession, even if it is a *little* pin, you are bound to upset the watch in the long run, even though the damage may not "show up" as quickly as when you jam a fair-sized nail into the works. The same thing is true of "coal gas." A sudden large amount of coal gas knocks a person senseless in a few minutes: you have all heard about the people found dead in their garage, when the doors of the garage were closed and the automobile engine was running, just as you have heard of people found dead in their room, with the windows closed and the stove "damped down" or the illuminating gas flooding the room. In either instance those people were *killed* by the "coal gas," the carbon monoxide contained in the "exhaust" of the car, the "fumes" of the stove and in the escaping illuminating gas. For, and this is a thing to be remembered by everybody, *"coal gas can be produced from any kind of fuel,* coal, wood, gasoline, kerosene and even paper, *when the fuel is not completely burned,* when it is allowed to "simmer" or smolder or smoke.

How does coal gas manage to kill in big amounts and to damage the body machinery in small amounts? If it is not a "poison" in the strict sense of the word, why does it act like a poison, so that we are fully justified in calling it "a toxic gas?" Coal gas attaches itself to the red blood bodies. It does not destroy the red corpuscles to which it sticks for the time being, but it prevents that red-blood body from doing its work, from carrying oxygen to the other cells. Since every cell in the body needs oxygen to keep going, you can easily understand that, the more the red cells happen to be occupied carrying coal gas, the less oxygen will be carted about for the benefit of the body as a whole. The result may be that of a stick poked between the cog-wheels of the body engine, preventing it from "running properly," because of the oxygen "shortage."

The next question is, how much coal gas is needed to kill a person? That depends on two things. First, the actual *amount* (or concentration) *of gas;* second *the length of time during which the gas is inhaled. The effect of a larger amount in a shorter time, equals the effect of a smaller amount during a longer time.* Henderson and his fellow workers tried to discover the exact amount of coal gas which *inhaled for one hour would be sufficient* to render a person unconscious and also the smallest amount which might be inhaled for one hour without producing "visible" symptoms. The exhaust gas of a Ford was used in these experiments. The Ford was made to run in a small enclosed "garage" specially built for the purpose. The experimenters locked themselves in with the Ford and tried how much exhaust they could stand for one hour at a time. The amount of exhaust could be regulated by letting in more air and by testing the "concentration" in the air of this "garage" by various means. The experiments are truly heroic, because inhaling carbon monoxide is not only dangerous, but even small amounts, which do not actually kill one, can make one feel exceedingly miserable. The men who did these experiments on themselves were all volunteers, many of them were students at Harvard University. When they inhaled carbon monoxide exhaust, in a concentration of *6:10,000 for one hour* they all suffered more or less severely: one of them had to go to bed and vomited for five hours; another had a raging headache for 72 hours, that is a headache lasting three whole days, (and a very severe one at that), following exposure to very much diluted exhaust gas, for only one hour. To give you a clear and concise

picture of these very important experiments I shall put them down in two tables.

Effects of Carbon Monoxide (Table I).
(as given by Yandell Henderson in J. of Industr. Hygiene, 1921, July, Aug.)

Concentration X Exposure equal 3—no symptoms.
or 3:10,000 for 1 hour

Concentration X Exposure equal 6—*Symptoms.* (headache nausea, giddiness)
6:10,000 for 1 hour.

Concentration X Exposure equal 9—Severe symptoms (victims likely to faint)
9:10,000 for 1 hour.

Concentration X Exposure equal 15—Dangerous (victims almost sure to faint)
15:10,000 for 1 hour.

Symptoms of Carbon Monoxide Poisoning (Table II).
(shown by Yandell Henderson's volunteers)

Concentration, 6:10,000—Exposure 1 hour.
severe throbbing headache—5 to *72 hours.*
Vomiting—up to *5 hours.*
Nausea—8 to *48 hours.*
Dizziness and headache—9 hours.
Weakness in the legs, faintness—up to 20 hours.
General lethargy (drowsiness)—up to 24 hours.

In table I the thing to be remembered is that 1x6 equals 2x3, so that exposure during *two hours* to a concentration of 3:10,000 (which gives "no symptoms," that is no *demonstrable* symptoms in one hour) is quite capable of producing the very unpleasant symptoms experienced by Henderson's volunteers and enumerated in table II. Another thing to be borne in mind is that one or other of those unpleasant symptoms may predominate in a given person: one may suffer chiefly from headache and only feel a little sea-sick, another may be terribly sea-sick: a third may feel chiefly "lethargic," that is, drowsy or "dopy." For it is a well known thing that the same poison may affect different persons somewhat differently. If three men get drunk on the very same whiskey, one of them may become merely "jolly" and sing; the second becomes quarrelsome and the third may get "weepy." The result depends on the person rather than on the poison; just as "influenza" gives one patient little more than a severe "cold," but makes another patient very seriously ill.

A third thing to be remembered is that the exhaust gas used in these experiments was *diluted.* If it had been "straight" undiluted, it would have *killed* everyone of the experimenters. *For auto exhaust gas contains as much as from 4-9 per cent of carbon monoxide,* that is nearly 1000 times as much as the concentration inhaled for one hour by Henderson's volunteers, and with such unpleasant results. No wonder people are found dead, when they let their cars "run" in a closed garage. Fortunately, when we are in the open air, the exhaust of autos is always diluted and a good deal may be blown away. The fact remains, however, that the number of automobiles and trucks in the world has increased very rapidly during the last ten years. Every automobile and every truck puts out exhaust, of which we all inhale a little, perhaps many times a day. True, we breathe it out again, it does not remain in our bodies, but it does create an oxygen deficit in our bodies for the time being. The great question is whether or not our bodies are likely to object to a "small oxygen deficit," repeatedly, even if for a short time. Considering the small size of the body cells, the minute amounts of important chemicals with which the cells work and to which they respond, it would seem impossible that the delicate body machinery could be really indifferent to even those amounts of carbon monoxide which do not produce immediate symptoms of intoxication. The moral of this story is neither dull nor "preachy," but eminently practical, namely: Warn both your friends and your patients about the dangers of exhaust gas and the harm that it is capable of doing. Avoid getting into the "firing-line" of an "exhausting" automobile; exhaust gas is poisonous in its action, the less you inhale of it the better it will be for the smooth running of your own body engine. Remember the body cells respond to *adrenalin,* a "home product," (made and used by the body all the time) in a concentration of one in three hundred millions. Our visualized data showed that such a concentration is equal to a very small wineglassful diluted with the content of six miles of sprinkling carts. Is it likely then, that the body cells should *entirely fail* to be affected by far greater concentration of a gas which behaves like a deadly poison? The increase all over the world of combustion products, all of which contain some carbon monoxide, is one of the great medical problems on which visualized data have a very definite bearing.

The other great medical problem is the Cancer Problem, to the discussion of which attention has been called during the last week of October, 1921, throughout the whole of the United States. *The relation of "visualized" data to the Cancer Problem.* Cancer is on the increase. This has been proved by Dr. Hoffman's statistics and is now generally admitted. The question is: Why should cancer be on the increase? Medical science has made great strides during the last ten years. Many diseases, tuberculosis for example, are treated with far more success, the number of victims of these diseases show a slight yearly decrease. The number of patients suffering from cancer in the United States and throughout the world shows a steady, yearly increase, which is particularly striking if we compare the statistics of 1921 and 1912. So far we do not even know the cause of cancer. Perhaps it would be better to say the "causes," for I believe that many factors may help to produce cancer. It is my personal conviction that cancer is one of the diseases caused by "poisons" which the body itself manufactures, something like the coma in diabetes or in uremia. We have seen that both in diabetes and in fatal nephritis, the organs which ought to do the work of chemical laboratories have become damaged and incapable of doing good work. The comatose condition of the patient is merely the result of the careless work done by the pancreas or his kidneys. But, both pancreas and kidneys may have been damaged and "put out of commission" by many different causes, just as you may break your leg in fifty different ways—by falling down stairs, or slipping on an orange peel or stumbling over the cat!

If, as I believe, cancer is the result of "wrong chemistry" within the body, many inside and outside factors may help to produce this bad chemistry by damaging one or more of the body's chemical laboratories. We have seen that the body is a very delicately adjusted machine, working with many chemicals in ridiculously small amounts; that it may be influenced for "weal" or "woe" by extremely "little" things; that invisible bacilli are capable of causing its destruction, when they dislike their dinner and turn upon their host and that so small an amount of carbon monoxide as 6:10,000—that is, about a teaacupful (150 c.c.) diluted with 625 gallons, the content of one average sprinkling cart—was enough to cause the severe symptoms experienced by Henderson's volunteers.

It is true that these symptoms lasted but three days at the longest, but the question presents itself: "Has the body really forgiven and forgotten the result, when the visible symptoms are over?" The observations of Green suggest that the body resents things, which it does not seem to notice. Green found that there is a connection between the amounts of combustion products in the air and the cancer incidence in a great number of localities. This is a very important observation. *During the last ten years the increase of combustion products in the world and the increase of cancer would seem to have gone hand in hand.* There has been an increased production of combustion products, discharged into the air by chimneys, factories, steamers, trains, and automobiles. There were but *one million* of automobiles and trucks in 1912 in the U. S., in 1920 there were no less than close upon *ten millions.* The exhaust of the smoothly running automobile, burning gasoline, contains 4-6% carbon monoxide, as

Teague of the Bureau of Mines has proved; the exhaust of a truck burning "benzol" contains other highly toxic compounds as well. The tiny body cells take notice of unbelievably small amounts of adrenalin, (10 c.c. in six miles of sprinkling carts); do they really fail to notice the carbon monoxide content in all those combustion products? May not these combustion products help to upset the body chemistry, thus paving the way for the development of cancer? This may prove to be another instance of the importance of seemingly "little" things. But, unless we "visualize" and *keep in mind* the diminutive size of the cells and the infinitesimal quantities by which they are affected, we shall be tempted to conclude that combustion products cannot possibly play a part in the increase of cancer. Yet the oxygen deficit, small and temporary though it may seem, which is caused by the inhalation of carbon monoxide, may be an *important factor* (though not the only one) in the cancer problem. While none of us here can do very much towards reducing the amount of combustion products in the world there are things which we can do and which may count after all. We can keep a watchful eye on furnaces and gas fittings. We can be careful not to inhale more exhaust gas than is absolutely unavoidable. We can warn our friends not to poison their neighbors and themselves by letting their cars "exhaust" unnecessarily. An automobile need not puff out clouds of evil-smelling smoke on a warm sunny day: if it does, the engine is dirty or the carburetor badly adjusted: in which case the car is merely wasting fuel as well as producing poison. It is only when the weather is cold and the car has been standing for a long time that there is any excuse for this.

In closing I would like to remind you of an important fact, which strange to say, is often forgotten. It is, that you cannot miss seeing an elephant; but you may have an awful hunt for a flea—even when he is making your life miserable!—It is the "little" things in life, that count. Nurses and doctors both, whose joint work it is to lessen the misery in this world, can hardly choose a better motto than:

"Lots of attention to 'little' things."

COMMENCEMENT EXERCISES AT MERCY HOSPITAL TRAINING SCHOOL, BALTIMORE, MD.

On Tuesday, May 9th, 1922, at 3:00 P. M., Mercy Hospital Training School for Nurses held its twenty-first annual commencement at the Lyceum Theater, Baltimore, Md.

When Archbishop Michael J. Curley presented the thirty diplomas at the graduating exercises, Sister Mary Joan of Arc Wilson was announced as having attained the highest average for theoretical and practical nursing. This is the second time she has won distinct honors, having received a gold medal for highest average when graduated in 1920 from the Maryland University School of Pharmacy. Sister Mary Joan of Arc is the daughter of Mrs. Carrie A. Wilson of Forest Park, Md., and sister of Commander P. L. Wilson of the Navy. She has been in the Order of the Sisters of Mercy for the past twelve years.

Miss Mary Christina Pottorff, of Pennsylvania, ranked second in the class; Miss Anna Baile, Chenoweth, Md., third, and Miss Virginia E. Geise, Maryland, fourth. Other graduates from Maryland were: Miss Rose Brunsman, Mary Elizabeth Dempsey, Catherine Spalding Donovan, Margaret Howard Dudley, Frances Boucher Donovan, Martha Elizabeth Flynn, Helen Agnes Lyng, Helen Loretta Miller, Elizabeth Virginia Phelps, Catherine Frances Prenger, Elizabeth Gwendolyn Ruffli, Mary Gladys Scherer, Anne Margaret Sheridan, Elizabeth O'Donnell Street; from Virginia, Miss Laura Augusta Greaver; West Virginia, Miss Emma Garrison Burdette, Miss Georgia Seymour Harness, Miss Mildred Kathryn Hoffman, Miss Hallie Ruth Matthews; from Pennsylvania, Miss Helen Louise Blocker, Miss Eleanor Margaret Brubaker, Miss Julia Buhrman, Miss Burnetta Anna Heininger, Miss Lillian Ann Smith, Miss Lillian Ann Todt; Ohio, Miss Mary Sabina Breen.

Only the archbishop, the speakers, and the graduates occupied the stage. The undergraduates occupied boxes, and the Sisters were in the gallery. During the intermission music was furnished by an orchestra concealed in an upper box.

GRADUATING CLASS, MERCY HOSPITAL, PITTSBURGH, PA.

In addition to the Archbishop, speeches were made by Rev. Joseph E. Mallon and Dr. Walter D. Wise. Rev. Albert E. Smith offered the opening prayer. Archbishop Curley occasioned much merriment when he voiced a protest against the rather serious music and the grave faces of the audience and reminded them that he came from a land of smiles. After he finished speaking the orchestra struck up a lively melody and the Archbishop nodded approval.

In his address the Archbishop dwelt upon the power of personality and the pleasing qualities that people look for, especially in the nursing profession. "Who wants to be nursed by a sour nurse?" he asked. Dwelling upon organized charity as a result of Christianity, the Archbishop said only in pagan Ireland was there a hospital before the Christian era, and that was run by a woman. "But then, you know," said the Archbishop with a laugh, "Ireland always is nice." "This age never cherished a vainer delusion," said Father Mallon, "than when it thought it had discovered woman." "Woman," he said, had always been glorified by the Catholic church. He warned the graduates against the low moral standards of the day and urged them not to allow their ideals to be dragged down.

Dr. Walter D. Wise, who followed Rev. Mallon, spoke on the meaning of graduation day, the opportunities and responsibilities of the graduate nurse, and the need of courage, endurance and steadfastness in the work which the graduates have undertaken. Dr. Wise said in part:

"Graduation from the training school entitles you to sincere, not perfunctory congratulations. It signifies that you have maintained a high standard in other things besides the theory and practice of nursing. The diplomas you receive mean that you have met the requirements of the Sisters and these requirements are correctly rigid.

"As you develop you will wield a wider influence. What is this influence to be? Let me urge an effort to combat much that is modern. Refinement is being supplanted by coarseness and laxness which seem without limit. Throw the light of your influence against, and strongly against the attitude of the average modern young women who have raised the standard in this country so high. Throw the weight of your influence against the all-pervading spirit of materialism whether it be that which has entered into business or that which has crept into religion.

GRADUATING CLASS, MERCY HOSPITAL, HAMILTON, OHIO.

"As nurses, you will travel many seas and be in many storms. You will see many ships in trouble and many shipwrecks. Try always to have the lens of your searchlight polished, your masthead lights shining, your tow rope strong, but above all, do not neglect the important lights of love and kindness. Go then, out on the sea of your activities with these lights burning and carry with you all the cheer and comfort that there is within you to carry."

NURSES' GRADUATION.

Seven nurses of All Souls' Hospital Training School, Morristown, N. J., were presented with diplomas and pins at the annual commencement exercises, held in the hospital chapel on May 11th. Diplomas were awarded by Rev. Father Edward J. Ellard, president of the hospital, while the address to the graduates was given by Rev. Henry G. Coyne of Newark.

Father Ellard briefly congratulated the graduates on their successful career and wished them success in the future. Father Coyne, who followed, urged that the nurses model their lives on the life of the greatest of all models—Our Savior. There has always been, and always will be affliction, said Father Coyne, and those who are merciful to the suffering will also receive mercy. He gave the graduates some good advice as to their health, moral duties and future career and advised them not to be too loquacious Following the address, Father Ellard presented the diplomas and pins. The service concluded with the benediction of the Blessed Sacrament, given by Father Ellard, and the recessional.

Following the exercises, there was a reception at the Nurses' Home for the families and friends of the nurses. In the evening. the two under classes entertained the graduates at the Home.

GRADUATION DAY AT ST. JOACHIM'S HOSPITAL, WATERTOWN, N. Y.

On the morning of the 21st of April, the Graduates, as is customary, attended Mass, and received Holy Communion, thus proving that in the noble career about to open before them, they desired God to hold first place.

In the evening the exercises were held in the Knights of Columbus hall, where a beautifully decorated stage had been arranged for the occasion. The Graduates, ten in number, were seated five on each side of the stage, while in the center were Rev. Joseph L. Cole, pastor of St. Patrick's Church. Mr. Charles Norris, a prominent lawyer of Carthage, N. Y., Mr. R. Baker, member of the Chamber of Commerce, and Dr. Harlow G. Farmer, surgeon on the hospital staff. At the back of the stage were Sr. M. Sebastian, Superintendent of Nurses, Mrs. David Fandrey, president of the ladies' auxiliary, and little Rosemary Ward, the flower girl, who presented each nurse with a beautiful boquet of flowers. Mr. Baker gave the opening address, which was both practical and instructive. Dr. Farmer introduced the Graduates and in a few words expressed his approval of their splendid work while in training, and also his appreciation for their devoted assistance to him. He then presented Mr. Norris, the speaker of the evening who, although directing his remarks principally to the graduates, left upon the minds of all present, beautiful thoughts and lasting impressions. Sr. M. Sebastian then called the roll, and each graduate as she was called advanced to receive her diploma from Dr. Farmer, after which she received from Mrs. Fawdrey her class pin. After the awarding of diplomas, the graduates recited the Florence Nightingale pledge. Rev. Father Cole then gave the blessing during which all knelt. A musical program formed a part of the evening's exercises. After the exercises, the hall was cleared for a dance.

COMMENCEMENT AT MERCY HOSPITAL, HAMILTON, O.

The annual commencement exercises of Mercy Hospital Training School at Hamilton, O., took place on May 17th. Dr. Mark Millikin, president of the executive staff of the hospital, presented the diplomas and medals. The speakers of the evening were Mr. R. M. Hughes of Miami University, Oxford, and Rev. M. F. Griffin, Youngstown, O.

At the exercises, ten nurses were graduated. The program was unique, the printed designs having been made by two of the nurses. The medals for excellence in work were presented as gifts of the Women's Auxiliary of Mercy Hospital. The special Mathias Scholarship worth $500 went to Miss Nano Paul, who leaves in September to enter Columbia University where she will study for a B. S. degree. The scholarship is awarded to each year's graduating class by Mr. and Mrs. Homer Gard of Hamilton.

On Thursday, May 18th, high mass was celebrated in the hospital chapel by Father Alexander Wilberding for the members of the graduating class. At 2:30 P. M. the members of the class of 1922 were received into the alumnae association.

The alumnae banquet was held at the Hamilton Club, where the guests were entertained during the dinner by the sweet strains of the harp. Following the banquet the nurses were driven to the Butler County Country Club where they were the guests of Dr. Millikin, chief of the hospital staff.

COMMENCEMENT EXERCISES AT MERCY HOSPITAL, PITTSBURGH, PA.

The commencement exercises of the Mercy Hospital School of Nursing, were held April 24th in the Soldiers' Memorial Hall, Pittsburgh, Pa. A special program of music and addresses was given. Rev. James R. Cox presided at the exercises. Among the speakers were Dr. W. W. G. Maclachlan, Dr. John G. Bowman and Rt. Rev. Hugh Boyle.

The graduating class was entertained in the evening by the alumnae association at their annual ball in the Schenley Hotel. The ball was attended by many prominent persons from Pittsburgh and surrounding towns. Miss Catherine Quigley was the general chairman of the ball, assisted by Miss Hilda E. McAtee of the patronesses' committee.

On Friday evening, the senior members of the school entertained the graduating class in the reception room of the nurses' home. Following the entertainment a lunch was served. The room was decorated with the class colors, white and blue, together with ferns and cut flowers. The following address was written and read by Miss Genevieve King, a member of the senior class:

"The retrospect of three years in training-school that is present tonight to the mental view of this year's graduates, is, like every summoned vision of days that are gone, a picture of varied tints, of lights and shadows. There are in this picture the deep tones of trials and tears and the gay colors of laughter and gladness. It is a picture painted by time with the pigments of experience; its colors laid with the brushes of days and hours on the unfailing canvas of the memory. It was not done on any plan, well-known and formed before the painting. Its execution seemed, in large measure, haphazard. And yet I am sure that to every one of our guests this evening the memory picture of the three years just gone is not a meaningless jumble of color, but a clear and perfect whole. And as passing time enriches its coloring and as parting makes it dear, it will be removed from the easel of mere memory to be placed in the more honored gallery of the heart.

"For whatever of sadness and suffering the training school has had for these pupils—and it would be foolish to say that it has had none—it has had much more of happiness. If, in the common judgment of men, school-days are happy days, surely the training-school days, with their close comradeship and intimate associations must be the very happiest days. The triteness of this inference does not rob it of its truth.

"But I do not wish to say that the class of 1922 will take with them, when they leave us, only memories of happy days, they will take much more, and more highly valuable things than this. They will go from us as professional women, trained in the art and science of nursing: prepared to do that good in the world that only trained women can do. They will do good, not from a mistaken principle of altruism, not from the principle of the "brotherhood of man," but from the principle of the fatherhood of God. They will do this, because their training has taught them that one serves best one's fellowmen by best serving God. They will go from us trained in mind and soul: they will have character. They will be leaders of women. These are the things of great price that the backward glance of our graduates must see as the best of the fruits of the training years."

GRADUATING CLASS, ST. JOACHIM'S HOSPITAL, WATERTOWN, N. Y.

Banquet for Graduate Nurse. A graduate banquet was given at Mercy Hospital, Manistee, Mich., in honor of Miss Faye Prine, 1922 graduate. Following a six-course dinner in the hospital dining room, Miss Prine was presented with the diploma and class pin. She received several gifts of linen and silver.

St. Catherine's Graduation Exercises. St. Catherine's Hospital at Kenosha, Wis., held its 1922 graduating exercises on Thursday, June first, in St. George Hall. A class of nine was graduated.

Five Nurses Graduate. Five young women of the Mercy Hospital Training School at Scranton, Pa., were given diplomas of graduation at the exercises held on June first. Bishop M. J. Hoban who presided, presented the diplomas. The commencement address which was delivered by William F. Shean, brought out the point that the mark of the professional nurse is the love of God, Christian charity, love of one's neighbor and loyalty to the ideals of the profession. Following his talk, the bishop conferred his blessing upon the class.

Graduating Exercises. The graduating exercises of St. Mary's Hospital, Minneapolis, Minn., were held May 4th at the hospital auditorium. A class of 34, consisting of two Sisters and 32 lay nurses was graduated.

(Continued on Page XXVII)

How Hospital Day Was Observed in Catholic Hospitals

Hospital Day. National Hospital Day, May 12, was fittingly observed at Mary's Help Hospital, San Francisco, California. The feature of the celebration included open house all day, and a cordial invitation to the public to visit the various departments of the institution. Several hundred "National Hospital Day Buttons" were distributed.

In the evening an appropriate program was rendered by the nurses, consisting of music, recitations and drama, all the nurses reciting the Florence Nightingale Pledge, a copy of which was presented to each nurse. The closing number was the singing of the Star Spangled Banner. Refreshments, dancing and music terminated the day.

National Hospital Day at Hotel Dieu Hospital. National Hospital Day was observed at Hotel Dieu Hospital, Chatham, N. B., on May 12th, with James P. Waddleton in charge. The hospital held open house for the benefit of the public and there was a program consisting of a well-baby clinic, a luncheon for the visiting clergymen, members of the town council and the medical staff, a band concert, and an illustrated lecture by Dr. Marven, vice-president of the medical staff. Rt. Rev. Bishop Chiasson was a distinguished visitor. The program of the day was prepared by the Mother Superior and Sisters of the hospital, assisted by the Ladies' Hospital Aid. In the foyer of the hospital, the Mother Superior and the Assistant Superior received the guests who crowded the building. Before departure each guest partook of a lunch served by the members of the Ladies' Aid. In the evening the Citizens' Band played for an hour on the grounds in front of the building. The music was adapted to the needs of sick people and was sweet and soothing.

The auditorium of the academy building served as the meeting place for those who gathered to hear the lecture given by Dr. Marven of the medical staff. The subject of the lecture which was "Tuberculosis" was treated from the standpoint of prevention and care in the incipient stages of the disease. The lecture was well illustrated with a number of lantern slides, which emphasized the various points in the address and proved far more instructive to the audience than the perusal of many books. At the close of the address, the orchestra of St. Michael's Academy rendered a number of fine selections, bringing to a fitting end the day's observance.

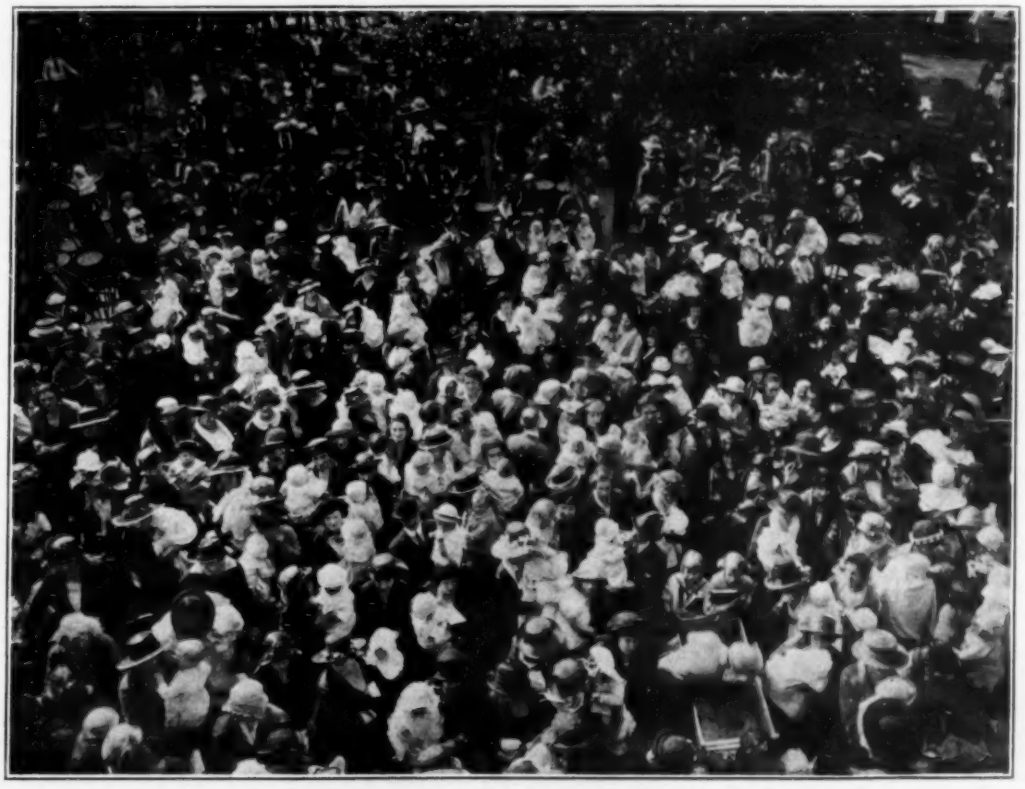
Observe Second Hospital Day. May 12th was observed as the second hospital day by Providence Hospital, Everett, Wash. The day was also the graduating day for the senior nursing class, five of the nurses having completed their course of training. The exercises which were held in the main assembly hall of the hospital were in charge of Dr. W. D. Smith.

Dr. W. F. West in his address, discussed "The Duty of the Nurse as She Goes Out on Practice." Rev. Father A. S. Fischer of Everett, wished the young ladies success, and the diplomas were presented by Rev. Father P. O'Donnell, chaplain of the hospital. The medals for excellence in work were awarded by the Sister Superior, after which the graduates recited the Nightingale pledge in the presence of the audience. The program was closed with the singing of a song.

During the day the hospital kept open house and served a special dinner to the patients. The following day, the nurses were entertained at dinner by Dr. Quigley, with an informal dance at the K. C. Hall.

Graduation on Hospital Day. In honor of Florence Nightingale, Hospital Day was observed May 12th, at St. Anthony's Hospital, Rock Island, Ill., with the graduation of six nurses of the senior nursing class. Disabled veterans of the world war, who were confined in the hospital, were remembered with candy, fruits and flowers and the day was turned into a visiting day for everyone.

The influence of Florence Nightingale, the honor of the profession and the credit due the nurse of today were all discussed in talks by Supt. E. C. Fisher of the city



SIX HUNDRED BABIES—ALL BORN AT THE HOSPITAL—GATHERED AT ST. MARY'S HOSPITAL, PASSAIC, N. J., ON NATIONAL HOSPITAL DAY. THIS IS A VIEW OF PART OF THE CROWD.

"HOSPITAL DAY," MAY 12, 1922, AT HUBER MEMORIAL HOSPITAL, PANA, ILL.
East End of Hospital, Where Addresses Were Heard From Balcony. Sisters Preparing Float, "The Spirit of Charity," for Hospital Day Parade.

schools, Mayor Schriver and Father P. H. Durkin of St. Joseph's Church. The speakers all offered their congratulations to the six young women who were presented with diplomas in nursing.

Observe Second Hospital Day. The second hospital day was observed by the Sisters and nurses of St. Francis Hospital, Grand Island, Neb., on May 12th. Open house was held from nine in the morning until seven at night. In the evening the nurses gave the play "A Probationer's Dream," a production originated and worked out by two sisters of St. Francis Hospital, Colorado Springs, Colo. An audience of eight hundred persons which completely filled the city's largest theater, gathered to witness the production given by the nurses, assisted by local talent.

Father Constant, chaplain of St. Francis Hospital, who gave an address previous to the play, explained the meaning and purpose of hospital day, the importance of the hospital in the community, the wonderful work done in the hospital and the necessity of modern and standardized institutions.

Hospital Day at St. Joachim's Hospital. Friday, May 12th, was observed as Hospital Day at St. Joachim's Hospital, Watertown, N. Y., with an open house for the benefit of the community. The visitors were received by the Sister Superior and the Superintendent, and were shown through the building by graduate nurses of the institution.

Following an inspection of the main hospital building by the visitors, the nurse conducted the party across the street to a smaller building containing the maternity and hydrotherapy departments. The nursery, with its rows of pretty cribs, appealed to the people more than anything else. The nurses' home which was the last department visited served as the resting place of the visitors. Here refreshments were served, after which the guests departed for home well pleased with the afternoon's adventure.

Hospital Day Celebrated. Mercy Hospital, at Cedar Rapids, Ia., celebrated Hospital Day on Friday, May 12th, when visitors were given a splendid idea of the inner workings of a hospital. From three to four in the afternoon, babies born in Mercy Hospital during the past two years were the guests of the hospital. A large number of babies brought in by their parents in accordance with a special invitation, was one of the beautiful features of the keeping of Hospital Day.

A select program of music and addreses was given for the occasion. Doctor Neuzil made an address on "The Administration of a Hospital." He gave his audience a concise statement of the business side of running a hospital successfully, and of the executive and administrative ability that a hospital requires, also of the demands that a hospital may fulfill properly and satisfactorily its mission to the individual and the community.

Miss Harriet Leete of Baltimore, who acts as field director of the American Child Hygiene Association, gave a short address on "The Due and Proper Care of the Newborn Child." Mayor Huston of Cedar Rapids also addressed the audience on "The Importance and Work of a Hospital Among the Community."

National Hospital Day Officially Observed. Mary Immaculate Hospital at Jamaica, N. Y., officially observed Hospital Day on Friday, May 12th, when it held open house and welcomed a large number of visitors to the institution. On the following Sunday, the principal observance of the event was held, and there were a number of novel features attracting wide attention and bringing several thousand visitors to the institution.

One of the features was an exhibition of the six hundred babies born in the institution within the last two years. The babies and their parents gathered in King's Park, directly across from the hospital. Each child was presented with a toy balloon given by the Sisters of the hospital, and the little ones were permitted to romp about the wide lawn. A concert was given for the benefit of the guests by the band of St. Vincent's Home in Brooklyn, an institution in charge of the Dominican Sisters, at the head of which is Rev. L. H. Bracken. The guests were later served with coffee, sandwiches and ice cream on the hospital grounds.

A stirring address was made by Rev. Thomas A. Nunmey, rector of the Church of the Holy Child Jesus of Richmond Hill, who has taken a great interest in the hospital. The buildings were open to the public and several thousand visitors were escorted through by the Mary Immaculate Hospital Association and the Ladies' Auxiliary. The visitors were given an opportunity to see how accident cases are treated as several such cases were brought in during the afternoon. Those outside the hospital were shown how injured persons are carried from an ambulance.

At the nurses' home a group of nurses received the visitors and impressed upon a number of girls the advantages of a course in nursing. The visitors were impressed with the apparent need of a larger building and a number of donations were made to the Sisters for the building fund. During the afternoon, the Daughters of Charity, one of the hospital's auxiliaries, gathered contributions from passing motorists which amounted to $500. The success of hospital day was attributed to the untiring efforts of Mr. Thomas F. Daly, a member of the hospital association, and a friend of the institution.

Hospital Day First Observed. For the first time in its history, Huber Memorial Hospital, at Pana, Ill., observed National Hospital Day on May 12th, in an elaborate manner. On the same day, the cornerstone of the Villa St. John, the nurses' home, was laid with impressive ceremonies.

By request of the Mayor, the business houses of the city closed their doors between the hours of two and five in the afternoon, in honor of the occasion, and the citizens joined in making the celebration a success.

At two in the afternoon, a fine street pageant was formed under the leadership of Grand Marshal W. F. McTaggart and his committee, headed by Roy L. Fairbanks. Upon arrival at the hospital grounds, the parade broke up and the twelve hundred people composing it gathered about the Villa St. John to listen to the ceremony attending the laying of the cornerstone by Rev. Father J. P. Moroney.

Following the laying of the cornerstone, the people were invited to the east end of the hospital where seats were placed facing the first balcony of the fire escape from which the speakers delivered their addresses. Dr. R. C. Danford, chief of the hospital staff, acted as master of cermonies. Dr. Danford gave some pointed advice to the public as to the ethics that should prevail at all

times between the public, the doctors and the hospital. He showed that more people get well when cared for in the hospital than when cared for in the home under like conditions, and that hospital care is cheaper than home care provided anything like as good service is given. He mentioned the fact that of the nine sisters in the hospital, six are registered nurses and give their entire time to the care of suffering humanity.

The next speaker was Dr. L. D. Moorhead, dean of Loyola University School of Medicine of Chicago. Doctor Moorhead gave an interesting talk of almost an hour, dealing largely with the matter of standardization of hospitals, and paying special tribute to Huber Memorial Hospital by stating that it is now a one hundred per cent hospital in the matter of case histories, laboratory equipment, staff meetings, case discussions and floor service. In comparing hospitals of an earlier day with those of the present, Dr. Moorhead declared the former were no more than boarding homes for the sick when the efficient service of the present day is taken into consideration.

A history of Florence Nightingale, the patron saint of all nurses, was given by Miss Rouine Donovan, a student nurse, which proved interesting and instructive. Addresses were also made by Mayor Vidles, Rev. Father Moroney, Dr. J. H. Miller, and Miss Elizabeth Gregory.

At the conclusion of the formal exercises, the hospital was thrown open for the inspection of the public. The visitors were pleased with the neatness of the building and with the apparent efficient service of the institution. All went to their homes much enlightened and with a higher regard for the efficiency of the local hospital in caring for those in need of its services.

Baby Show at Hospital. St. Mary's Hospital, Passaic, N. J., celebrated National Hospital Day by holding one of the largest baby shows ever held in the country. More than one thousand invitations were issued to the mothers of babies born in the hospital, more than six hundred of whom responded. The entire assemblage of children, parents and friends was estimated at 1,500 persons. The lawn and the street in front of the hospital was transformed into an immense amphitheater for the accommodation of the hospital's guests.

Mayor J. H. McGuide of Passaic presided and made the opening address. Dr. Roger Dennett of the New York Postgraduate Hospital, and Dr. Julius Levy of the New Jersey State Bureau of Child Hygiene, also made brief addresses. The Boys' Band of Holy Cross Rectory, Harrison, N. J., furnished music.

In connection with the baby show, scores of prizes given by the local merchants and citizens of the community, were awarded the children. An important feature of the event was a prize of $10 in gold given by a life insurance company to the mother with the largest family. The prize went to Mrs. Catherine McDonald of Rutherford, the mother of eleven children. Five-dollar gold pieces were also awarded to two mothers of ten children each. The baby show was the prelude to a campaign which the hospital will conduct to raise $300,000 for the erection of an addition.

The new addition will provide a maternity department offering twice the present accommodations for maternity patients, emergency and general operating rooms, administration offices, laboratories and a children's department.

Western Hospital Observes National Hospital Day. National Hospital Day at Sacred Heart Hospital, Medford, Ore., was fittingly observed on Friday, May 12th, with an interesting program.

The doors of the hospital were open to the public from two to five o'clock and an invitation was extended to visit the institution and witness the fact that no effort is spared to assure patients the best possible care. Three special committees were in charge to receive visitors during the hours from two to three o'clock, three to four o'clock and four to five o'clock.

At three o'clock in the afternoon, an interesting program was rendered to an audience of several hundred persons. Mayor C. E. Gates addressed the assembled persons calling special attention to the noble work of the Sisters during the influenza epidemic, when many lives were saved through their devoted care. Musical selections were given by the Public High School and St. Mary's Academy. The ladies of the several clubs served simple refreshments to all present.

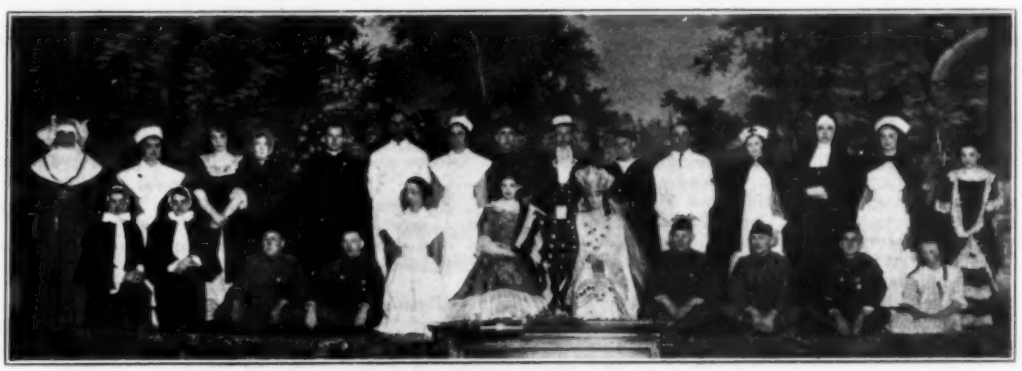
Hospital Holds Open House. Open house was held at Mercy Hospital, Tiffin, O., in observance of the second annual hospital day, commemorating the birthday of Florence Nightingale. Visitors to the institution were received from two to five o'clock, and from six to nine o'clock. The halls and corridors were decorated with flowers, bunting and flags, and refreshments were served during the afternoon.

National Hospital Day. National Hospital Day was observed at St. Luke's and St. John's Hospitals at Fargo, N. D., with the graduation of 29 nurses, seventeen from St. Luke's and twelve from St. John's. Mr. J. A. Garrity, who gave the principal address at the exercises, traced the history of nursing from the earliest time down to the present. Mr. Garrity showed that the good nurse is one who realizes that her work is a work of mercy and that what she does is reflected back upon the school.

Hospital Observes National Hospital Day. St. Mary's Mercy Hospital at Gary, Ind., on May 12th observed the anniversary of the birth of Florence Nightingale. During the day the hospital held open house for visitors. The hospital issued a small pamphlet giving some statistics of the institution and describing the work of caring for the sick and injured.

Hospital Improvements. A hospital staff was organized on April 1st at St. Mary's Hospital, Gallup, N. Mex. Since that time, improvements have been made in both the laboratory and x-ray departments. A sectional filing system has been installed and plans are going forward in the direction of hospital standardization.

Nurses' Retreat. The annual retreat for the student nurses of Creighton Memorial St. Joseph's Hospital at Omaha, Neb., was conducted May 17th to 20th by Rev. Father Flynn. The retreat closed with High Mass and sermon.



THE PROBATIONER'S DREAM.
Ensemble of cast of the clever play presented as part of the official Hospital Day Program at St. Francis Hospital, Grand Island, Neb.

The Question Box

This Department of the Magazine is intended for subscribers who have problems which trouble them. The editors will reply to questions which they can answer and to other questions they will obtain replies from competent authorities. Letters must invariably be signed with the full name of the inquirer, not necessarily for publication, but as evidence of identity and good faith. The privilege of printing any reply is reserved. Address, Hospital progress, 1212 Majestic Building, Milwaukee, Wis.

Authority In An Obstetrical Case.

133. Q: Please state a nurse's duty and authority in the obstetrical room at the time of delivery. Also, who is the highest authority at anytime during a delivery?

A: Obviously, the doctor is responsible for the delivery and the plan of the aftertreatment. Therefore, being thus responsible, he should be in authority to a degree consistent with the successful accomplishment of his work. The nurse is the doctor's assistant in his responsibility. Hence in this she should be under his authority. In matters apart from the above stated responsibility, the nurse is under the authority of her immediate superior who, in turn, is responsible to her superior.

Training School.

134. Q: Do you know of a hospital that would accept a colored girl as a pupil nurse? I am interested in such a case.

A. We are sorry to state that we have no information on this point. If any Sister can inform us in this regard, will she please communicate with this office, in order that we may help the enquiring Sister?

A Hospital That May Be Purchased.

135. Q: We have a hospital that we should like to have taken over by some other Sisters. Will you please tell us the best means of getting the information to the Sisters?

A: If you will send us complete information, we shall see that it reaches all of the Sisters' hospitals of the U. S. and Canada.

We now have a "service bureau" in the office of the secretary-treasurer, which is for just such service as you desire.

Reports of "Hospital Day", Etc.

136. Q: Are full reports of "Hospital Day" and graduating exercises to be published in HOSPITAL PROGRESS?

A: As much of each report will be published as is practicable. We shall try to please all. In this connection, we refer you to an editorial in this issue, under the caption: "Avoiding misunderstandings."

Transactions of 1922 Convention.

137. Q: Will the transactions of the 1922 Convention be published in book form?

A: No; they will be published in HOSPITAL PROGRESS, beginning with the August issue. The transactions have not been published in book form since those of the 1919 Convention.

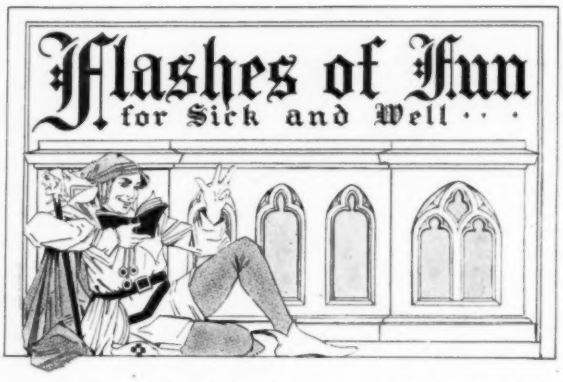
Hospital Planning and Construction.

138. Q: Can you give me a list of books on the planning and construction of hospital buildings?—R. E. O.

A: Below is a list of books on the planning and construction of hospitals. The latest work is Stevens' and the largest and most important is Hornsby and Schmidt's.

Stevens' American Hospital of the Twentieth Century, $7.50, Architectural Record, New York City; **Mackintosh's Construction, Equipment and Management of a Hospital**, $4.20, Chicago Medical Book Co., Chicago; **Ochsner and Strum's Organization, Construction and Management of Hospitals**, $8, Cleveland Press, Chicago; Bacon's Efficient Hospitals, Asa Bacon, Presbyterian Hospital, Chicago; **Atkinson's Orientation of Buildings**, $2, John Wiley & Sons, New York; **Bartine's Building of the Hospital**, O. H. Bartine, New York Homoeopathic Medical College.

Hospital Bequest. St. Mary's Hospital, Cincinnati, has received $2,000 and St. Francis Hospital $10,000, under the will of Mrs. Katherine Reisser. St. Anthony's Hospital, Rockford, Ill., has been left $2,000 by the will of Mrs. Margaret Toms.



WHAT WILLIE LEARNED AT MEDICAL SCHOOL.

Bill wanted to be a great surgeon,
And deftly remove people's hides,
In order to see what the trouble could be
That lurked in their painful inside.
So his father disposed of the hay crop,
And mortgaged the house and mule,
And Bill washed his ears, and for three weary years
Attended a medical school.
He heard pathological lectures
And patiently learned them by heart,
At clinics he saw, with a shudder of awe,
How people are taken apart.
He studied till two in the morning
By the light of the flickering gas,
And his work was so good in the lab. that he stood
Right up at the head of his class.
Great things were predicted for Willie
By the Docs, when he got his degree,
He was certain to shine when he hung out his sign
As William Alfalfa M. D.
He would gather in patients and riches
And climb to success over night,
Which is just what the kid very easily did,
Which proved that the Doctors were right.
But William, though rolling in riches,
Is not any shark with the knife,
He honestly owns that he cannot set bones
And never mixed pills in his life.
Yet patients from sunrise till sunset
Each day to his office resort,
And hurry away with prescriptions that say:
"R: Spirits fermenti: 1 Quart".

—The Optimist.

A Story.

Once upon a time a certain man fell sick and went to a hospital. There they placed him on the operating table, took out his stomach, turned it inside out, washed it out clean and hung it up on a fence to dry. When they went to fetch it again after about an hour they could not find it for the neighbor's dog had found and swallowed it. After a hurried consultation the doctors ran to the next farm, killed a goat, took out its stomach and sewed it on in the abdomen of the sick man. After a week he went home to his family.

"What is the matter with you," said his wife to him some time after, "you used to love beefsteaks, sausages, and meat in general. Now all you want me to prepare is lettuce and sauerkraut and all kinds of vegetables."

Money Is Power.

Surgeon: "A local anesthetic will be sufficient for your operation."

Mrs. Newlyrich: "I prefer an imported one; the price is no consideration."

An Unhealthy Climate.

Missionary newly arrived on the island, to one of the savages: "What for are you staring at me like that?"

Savage: "I beg your pardon, your Reverence, I am the food inspector of this place."

Missionary (after some silence): "Are my brethren who arrived two weeks before me, still on these shores?"

Savage: No, they went already into the interior."